

VS. A15ME(S)  
SM 9/55

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		d. STREET ADDRESS	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)		4. DATE OF DEATH	
5. SEX		6. COLOR OR RACE	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH	
9. AGE (In years last birthday)		10. IF UNDER 1 YEAR	
11. IF UNDER 24 HRS.		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.	
17. INFORMANT		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Intracranial hemorrhage</u> 816X DUE TO (b) <u>Fractured skull</u> DUE TO (c) <u>Automobile accident</u>		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Driver of an automobile in collision with another.</u>	
20c. TIME OF INJURY Hour a. m. <u>12.05</u> p. m. <u>3-22-1956</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Street</u>		20f. (City or town) (County) (State) <u>Fairmount Hts-Pr. Geo. Md.</u>	
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <u>John T. Maloney</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>John T. Maloney, M.D.</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL, ETC.		22b. DATE THEREOF	
22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
23. FUNERAL DIRECTOR'S SIGNATURE <u>John J. Rhiner Inc.</u>		24a. REC'D BY REGISTRAR DATE <u>3/23/56</u>	
24b. REGISTRAR'S SIGNATURE <u>Barbara J. Lounsbury</u>			

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE, MD  
STATE MEDICAL EXAMINER'S CERTIFICATE OF DEATH

BUREAU V. S.

MAR 27 1956

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital. The attending physician and complete this certificate has been signed by the attending physician and complete. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and complete. Pages 1 and 2 should be filed with page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# BALTIMORE STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3143

## CERTIFICATE OF DEATH

Reg. Dist. No.

031205

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Prince George's			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 15 Hyattsville, Maryland				c. LENGTH OF STAY IN 1b 6 weeks			
d. NAME OF HOSPITAL (If not in hospital, give street address) 90 Conv Home 5801 42th st. Hyattsville Md.				d. STREET ADDRESS 4014 Nicholson Street			
3. NAME OF DECEASED (Type or print) First Middle Last Mary Anderson				4. DATE OF DEATH Month Day Year March 11, 19 56.			
5. SEX female		6. COLOR OR RACE white		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Dec 1 1884	
9. AGE (In years lost birthday) yrs. 71		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY own home		11. BIRTHPLACE (State or foreign country) Washington D. C.	
13. FATHER'S NAME Joseph Anderson		14. MOTHER'S MAIDEN NAME Unknown		12. CITIZEN OF WHAT COUNTRY? U S A			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. (If yes, give war or dates of service)		17. INFORMANT Edwin M Anderson		Address 4014 Nicholson St., Hyattsville, Maryland.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 592x Cerebral Arterio sclerosis DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Chronic Glomerulo nephritis DUE TO (c) Hypertension						INTERVAL BETWEEN ONSET AND DEATH 5 years 5 years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from Oct 28, 19 55, to March 11, 19 56, that I lost the deceased olive on March 11, 19 56, and that death occurred at 8 P M, from the causes and on the date stated above.							
ACTUAL SIGNATURE Arnold A. Lear MD				ADDRESS (Street, city or town, state) 4314 Gallatin Street., DATE SIGNED 3/11/56.			
PHYSICIAN'S NAME (Type) Arnold A. Lear MD				Hyattsville, Maryland.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 3/14/56		22c. NAME OF CEMETERY OR CREMATORY Fort Lincoln Cemetery		22d. LOCATION (City, town, or county) Colmar Manor, Maryland.	
23. FUNERAL DIRECTOR'S SIGNATURE F. Gasch's Sons Hyattsville, Maryland.				24a. REC'D BY REGISTRAR DATE March 13, 1956		24b. REGISTRAR'S SIGNATURE James Perez	

CERTIFICATE OF DEATH

3153

1. NAME OF DECEASED		2. SEX		3. AGE	
4. OCCUPATION		5. MARITAL STATUS		6. PLACE OF BIRTH	
7. DATE OF DEATH		8. TIME OF DEATH		9. CAUSE OF DEATH	
10. PLACE OF DEATH		11. SIGNATURE OF PHYSICIAN		12. SIGNATURE OF REGISTRAR	
13. SIGNATURE OF WITNESS		14. SIGNATURE OF WITNESS		15. SIGNATURE OF WITNESS	
16. SIGNATURE OF WITNESS		17. SIGNATURE OF WITNESS		18. SIGNATURE OF WITNESS	
19. SIGNATURE OF WITNESS		20. SIGNATURE OF WITNESS		21. SIGNATURE OF WITNESS	
22. SIGNATURE OF WITNESS		23. SIGNATURE OF WITNESS		24. SIGNATURE OF WITNESS	
25. SIGNATURE OF WITNESS		26. SIGNATURE OF WITNESS		27. SIGNATURE OF WITNESS	
28. SIGNATURE OF WITNESS		29. SIGNATURE OF WITNESS		30. SIGNATURE OF WITNESS	
31. SIGNATURE OF WITNESS		32. SIGNATURE OF WITNESS		33. SIGNATURE OF WITNESS	
34. SIGNATURE OF WITNESS		35. SIGNATURE OF WITNESS		36. SIGNATURE OF WITNESS	
37. SIGNATURE OF WITNESS		38. SIGNATURE OF WITNESS		39. SIGNATURE OF WITNESS	
40. SIGNATURE OF WITNESS		41. SIGNATURE OF WITNESS		42. SIGNATURE OF WITNESS	
43. SIGNATURE OF WITNESS		44. SIGNATURE OF WITNESS		45. SIGNATURE OF WITNESS	
46. SIGNATURE OF WITNESS		47. SIGNATURE OF WITNESS		48. SIGNATURE OF WITNESS	
49. SIGNATURE OF WITNESS		50. SIGNATURE OF WITNESS		51. SIGNATURE OF WITNESS	
52. SIGNATURE OF WITNESS		53. SIGNATURE OF WITNESS		54. SIGNATURE OF WITNESS	
55. SIGNATURE OF WITNESS		56. SIGNATURE OF WITNESS		57. SIGNATURE OF WITNESS	
58. SIGNATURE OF WITNESS		59. SIGNATURE OF WITNESS		60. SIGNATURE OF WITNESS	
61. SIGNATURE OF WITNESS		62. SIGNATURE OF WITNESS		63. SIGNATURE OF WITNESS	
64. SIGNATURE OF WITNESS		65. SIGNATURE OF WITNESS		66. SIGNATURE OF WITNESS	
67. SIGNATURE OF WITNESS		68. SIGNATURE OF WITNESS		69. SIGNATURE OF WITNESS	
70. SIGNATURE OF WITNESS		71. SIGNATURE OF WITNESS		72. SIGNATURE OF WITNESS	
73. SIGNATURE OF WITNESS		74. SIGNATURE OF WITNESS		75. SIGNATURE OF WITNESS	
76. SIGNATURE OF WITNESS		77. SIGNATURE OF WITNESS		78. SIGNATURE OF WITNESS	
79. SIGNATURE OF WITNESS		80. SIGNATURE OF WITNESS		81. SIGNATURE OF WITNESS	
82. SIGNATURE OF WITNESS		83. SIGNATURE OF WITNESS		84. SIGNATURE OF WITNESS	
85. SIGNATURE OF WITNESS		86. SIGNATURE OF WITNESS		87. SIGNATURE OF WITNESS	
88. SIGNATURE OF WITNESS		89. SIGNATURE OF WITNESS		90. SIGNATURE OF WITNESS	
91. SIGNATURE OF WITNESS		92. SIGNATURE OF WITNESS		93. SIGNATURE OF WITNESS	
94. SIGNATURE OF WITNESS		95. SIGNATURE OF WITNESS		96. SIGNATURE OF WITNESS	
97. SIGNATURE OF WITNESS		98. SIGNATURE OF WITNESS		99. SIGNATURE OF WITNESS	
100. SIGNATURE OF WITNESS		101. SIGNATURE OF WITNESS		102. SIGNATURE OF WITNESS	

BUREAU V. S.

1956

RECEIVED



3144

## CERTIFICATE OF DEATH

Reg. Dist. No. 245

1. PLACE OF DEATH a. COUNTY <b>Prince George's</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Prince George's</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hyattsville</b>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hyattsville, Maryland.</b>			
c. LENGTH OF STAY IN 1b <b>4 years</b>							
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>3900 Hamilton St Apt B 102</b>				d. STREET ADDRESS <b>3900 Hamilton St Apt B 102</b>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First <b>Thomas</b> Middle <b>Charles</b> Last <b>Anglin</b>				4. DATE OF DEATH Month <b>March</b> Day <b>1</b> Year <b>19 56</b>			
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>May 18, 1898</b>		9. AGE (In years last birthday) <b>57</b> yrs.	IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired Printer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>self</b>		11. BIRTHPLACE (State or foreign country) <b>Georgia</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
13. FATHER'S NAME <b>William Henry Anglin</b>				14. MOTHER'S MAIDEN NAME <b>Susie M. Morriss</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>		16. SOCIAL SECURITY NO. <b>217 05 9476</b>		17. INFORMANT <b>Cecelia Anglin</b> Address <b>Hyattsville, Maryland.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Coronary Thrombosis with myocardial infarction</b> <b>420.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Arterio-sclerotic heart disease.</b> DUE TO (c) _____							INTERVAL BETWEEN ONSET AND DEATH —
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) <b>College Park, Md.</b>		(County) (State)	
21. I certify that I attended the deceased from <b>March 1, 1955</b> , to <b>March 1, 1956</b> , that I last saw the deceased alive on <b>March 1, 1956</b> , and that death occurred at <b>3:22 P. M.</b> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>4713 Berwyn Rd., College Park, Md.</b> DATE SIGNED <b>3/2/56</b>							
ACTUAL SIGNATURE <b>Loch. Etienne</b> M.D.							
PHYSICIAN'S NAME (Type) <b>Dr. Wolcott L. Etienne</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>Mar 5, 1956</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Fort Lincoln Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Colmar Manor Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>F. Gasch's Sons</b> ADDRESS <b>Hyattsville Maryland.</b>				24a. REC'D BY REGISTRAR <b>March 2, 1956</b>		24b. REGISTRAR'S SIGNATURE <b>Mrs. Jas. Severe</b> <i>Deputy</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18

BUREAU V. S.

MAR 5 1956

RECEIVED

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 3155 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. **03122**

1. PLACE OF DEATH a. COUNTY <b>Prince Georges</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Pr. Geo.</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>16 Mt. Rainier</b>		c. LENGTH OF STAY IN 1b <b>40 Years</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>16 Mount Rainier</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>00 4208 32nd. Street</b>				d. STREET ADDRESS <b>4208 32nd. Street</b>			
3. NAME OF DECEASED (Type or print) First <b>Maria</b> Middle <b>Baldwin</b> Last <b>Baldwin</b>				4. DATE OF DEATH Month <b>March</b> Day <b>9</b> Year <b>19 56</b>			
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>May 17, 1874</b>		9. AGE (In years last birthday) <b>81</b> yrs.	IF UNDER 1 YEAR Months <b>9</b> Days <b>19</b> Hours <b>56</b> Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Ireland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>James Long</b>				14. MOTHER'S MAIDEN NAME <b>Bridget Cambell</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>*****</b>		17. INFORMANT Address <b>Alice Perkins, 4833 16th. St. N.E. Wash. D.C.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Acute congestive heart failure</b> <b>443X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Hypertensive cardiovascular disease</b> DUE TO (c) <b>Essential hypertension.</b>							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <b>Chronic endocarditis</b>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Nat while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <b>John T. Maloney</b>				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED <b>March 9, 1956</b>	
EXAMINER'S NAME (Type) <b>John T. Maloney, M.D.</b>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>3-12-56</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Mt. Olivet Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Washington D. C.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Francis J. Collins</b>				D. C. ADDRESS <b>3821 14th. N.W. Wash.</b>		24a. REC'D BY REGISTRAR <b>3/12/56</b>	
				24b. REGISTRAR'S SIGNATURE <b>Maranda Doney</b>			

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

STATE OF MARYLAND  
 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Name of Deceased		Sex		Age		Date of Death	
Place of Birth		Usual Residence		Cause of Death		Manner of Death	
Occupation		Education		Medical History		Post-mortem Examination	
Family History		Social History		Clinical History		Gross Findings	
Microscopic Findings		Bacteriologic Findings		Chemical Findings		Other Findings	
Autopsy Report		Toxicologic Report		Pathologic Report		Final Report	

BUREAU V. S.

MAR 14 1936

RECEIVED

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 03123

## 3207 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. 243

1. PLACE OF DEATH a. COUNTY <u>Prince Georges</u> <u>MARYLAND</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Prince Geo.</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bowie</u>		c. LENGTH OF STAY IN 1b <u>X</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bowie</u> <u>Fletcherstown</u> <u>X</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Prospect Hill Road</u>				d. STREET ADDRESS <u>1</u>			
3. NAME OF DECEASED (Type or print) First <u>William</u> Middle <u>Nathaniel</u> Last <u>Bell</u>				4. DATE OF DEATH Month <u>March</u> Day <u>3</u> Year <u>19 56</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>Colored</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> <u>Separated</u> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>8-12-28</u>	9. AGE (In years last birthday) <u>27</u> yrs.	IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u>	IF UNDER 24 HRS. Hours <u>  </u> Min. <u>  </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Laborer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Construction</u>		11. BIRTHPLACE (State or foreign country) <u>Lanham, Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U S A</u>	
13. FATHER'S NAME <u>Webster H. Bell</u>				14. MOTHER'S MAIDEN NAME <u>Mildred Platier</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>0</u>		16. SOCIAL SECURITY NO. <u>216-22-1169</u>		17. INFORMANT <u>Raymond Bell Glendale, Md Box 183</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Asphyxia</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Carbonmonoxide poisoning</u> DUE TO (c) <u>Automobile exhaust fumes</u>							INTERVAL BETWEEN ONSET AND DEATH <u>  </u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>While trying to drive an auto. out of a ditch became asphyxiated by fumes.</u>					
20c. TIME OF INJURY Hour <u>9 a.m.</u> Month, Day, Year <u>3-3-56</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>street</u>		20f. (City or town) <u>Bowie</u>		20g. (County) <u>pr. Geo.</u>	
						20h. (State) <u>Md.</u>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <u>John T. Maloney</u>				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED	
EXAMINER'S NAME (Type) <u>John T. Maloney, M.D.</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		<u>March 3, 1956</u>	
22a. BURIAL, CREMATION, or REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>3-7-56</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Cheney Church Cemetery</u>		22d. LOCATION (City, town, or county) <u>Lanham, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>John T. Maloney</u>				ADDRESS <u>1820 9th St. N.E.</u>		24a. REG. BY REGISTRAR <u>3/4/56</u>	
						24b. REGISTRAR'S SIGNATURE <u>Mrs. Agnes W. Yingling</u>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.



# STATE MEDICAL EXAMINER'S CERTIFICATE OF DEATH

NAME OF DECEASED		AGE		SEX		RACE		DATE OF BIRTH		PLACE OF BIRTH	
JAMES H. HARRIS		45		Male		White		1880		New York	
RESIDENCE		OCCUPATION		EDUCATION		MARRIAGE		SINGLE		MARRIED	
123 Main St.		Teacher		High School		Married		Yes		No	
DATE OF DEATH		PLACE OF DEATH		CAUSE OF DEATH		MANNER OF DEATH		NATURAL		UNNATURAL	
March 8, 1956		Home		Heart Disease		Natural		Yes		No	
SIGNATURE OF EXAMINER		TITLE		COMMISSION EXPIRATION DATE		NOTARY PUBLIC		STATE		COUNTY	
J. H. Harris		Physician		1957		Yes		New York		New York	

BUREAU V. S.

MAR 9 1956

RECEIVED

3208

## CERTIFICATE OF DEATH

Reg. Dist. No. 243

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY Prince Georges		MARYLAND		STATE D. C.		COUNTY -	
CITY (If outside corporate limits, write RURAL OR and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
X TOWN Glenn Dale (rural)		1 mo., & 17 days		TOWN Washington		47X-3 ✓	
HOSPITAL OR INSTITUTION OR STREET ADDRESS Glenn Dale Hospital				STREET ADDRESS (If rural give location) 2551 17th St., N. W., Apt. #203			
3. NAME OF DECEASED: (First) JOHN		(Middle) R		(Last) BELLER		4. DATE OF DEATH: 3 6 1956	
5. SEX: Male		6. COLOR OR RACE: White		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Single		8. DATE OF BIRTH: 2/22/1878	
9. AGE last birthday: 78 yrs.		10. MONTHS: -		11. DAYS: 13		12. HOURS: -	
10a. USUAL OCCUPATION. Give kind of work done during most of working life, even if retired: Retired - unknown		10b. KIND OF BUSINESS OR INDUSTRY: Realty Co.		11. BIRTHPLACE (State or foreign country): West Virginia		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME: Frank Beller				14. MOTHER'S MAIDEN NAME: Sallie Rowan			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) No		16. SOCIAL SECURITY No.: Unknown		17. INFORMANT & ADDRESS: Decedent			
18. MEDICAL CERTIFICATION							
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						Interval Between Onset And Death	
162X Immediate cause (a) Bronchogenic Carcinoma left Lung						5 Mon Ths	
Antecedent causes (s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last. 002X (b) DUE TO (c)							
11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. Pulmonary Tuberculosis							
19a. DATE OF OPERATION:		19b. MAJOR FINDINGS OF OPERATION					
21. ACCIDENT SUICIDE HOMICIDE (Specify)		PLACE (Home, farm, factory, street, office bldg., etc.)		(CITY OR TOWN)		(COUNTY) (STATE)	
TIME (Month) (Day) (Year) (Hour) OF INJURY		INJURY OCCURRED While at Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from JAN. 18, 1956, to MARCH 6, 1956, that I last saw the deceased alive on MARCH 6, 1956, and that death occurred at 2:35 PM, from the causes and on the date stated above.							
SIGNATURE		(Degree or title)		ADDRESS		DATE SIGNED	
Daniel Lee Priess		M.D.		Glenn Dale Hospital Glenn Dale, Md.		3/6/56	
23. BURIAL, CREMATION, REMOVAL (Specify)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
Removal		3. 7. 56		-		Wash., D.C.	
DATE REC'D BY LOCAL REGISTRAR		REGISTRAR'S SIGNATURE		24. FUNERAL DIRECTOR		ADDRESS	
3/6/56		Aloe Green		Francis J. Collins		3821-14th St. N.W. Wash., D.C.	

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

MAR 13 1956

BUREAU V. S.

1

INSTRUCTIONS

**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

## MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

3209

## CERTIFICATE OF DEATH

03125

Reg. Dist. No. 234

<b>1. PLACE OF DEATH</b>				<b>2. USUAL RESIDENCE (HOME) OF DECEASED</b>			
COUNTY <u>Prince George</u>		MARYLAND		STATE <u>MD</u>		COUNTY <u>Prince George</u>	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
TOWN <u>Accokeek</u>		<u>9 yrs</u>		TOWN <u>Accokeek</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural give location)			
<b>3. NAME OF DECEASED</b> (Type or Print)				<b>4. DATE OF DEATH</b>			
(First) <u>Thomas</u> (Middle) <u>Louder</u> (Last) <u>Berry</u>				DATE <u>MAR 7</u> (Day) (Year) <u>1956</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <u>Single</u>	8. DATE OF BIRTH <u>12-17-1866</u>	9. AGE last birthday <u>89</u> yrs.	IF UNDER 1 YEAR		IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Laborer (Ret.) State Road</u>			10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) <u>Maryland</u>	12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>		
13. FATHER'S NAME <u>Not Known</u>				14. MOTHER'S MAIDEN NAME <u>Not Known</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT & ADDRESS <u>Dr. S. Elgie Day</u> <u>Accokeek, MD</u>			
<b>I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH</b>						INTERVAL BETWEEN ONSET AND DEATH	
18. MEDICAL CERTIFICATION							
422.2 IMMEDIATE CAUSE (A) <u>Chronic Myocarditis</u>						<u>3 yrs.</u>	
ANTECEDENT CAUSE(S) DUE TO							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO							
(C)							
11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u>Arthritis left Arm</u>						<u>9 yrs.</u>	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town)		(County) (State)	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>3/7</u> , 19 <u>56</u> , to <u>3/7</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>3/7</u> , 19 <u>56</u> , and that death occurred at <u>5:30</u> P.M. from the causes and on the date stated above.							
SIGNATURE <u>Frank A. Dusan</u>				ADDRESS (Street, city, town, state) <u>Indian Head, Md.</u>		DATE SIGNED <u>3-7-56</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>3-9-56</u>		NAME OF CEMETERY OR CREMATORY <u>Addison Chapel</u>		LOCATION (City, town, or county) (State) <u>Seat Pleasant Md</u>	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE <u>Mrs. Carrie Campbell</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Hunt Funeral Home</u>		ADDRESS <u>Waldorf Md</u>	
DATE <u>MAR 12 1956</u>							

RECEIVED



3210

## CERTIFICATE OF DEATH

03126  
Reg. Dist. No.

## I. PLACE OF DEATH:

COUNTY Prince George MARYLAND  
CITY (If outside corporate limits, write RURAL OR and give nearest town) Brandywine  
TOWN Brandywine  
HOSPITAL OR INSTITUTION OR STREET ADDRESS Home

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

STATE Maryland COUNTY Prince Geo.  
CITY (If outside corporate limits, write RURAL and give nearest town) Brandywine  
TOWN Brandywine  
STREET ADDRESS (If rural give location) RT 2 -

## 3. NAME OF DECEASED:

(First)

(Middle)

(Last)

(Type or Print)

FitzhughHooeBillingsley

## 4. DATE OF DEATH:

(Month)

(Day)

(Year)

DEATH:

March131956

## 5. SEX:

## 6. COLOR OR RACE:

## 7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify):

## 8. DATE OF BIRTH:

## 9. AGE last birthday:

IF UNDER 1 YEAR

IF UNDER 24 HRS.

MaleWhiteMarriedJune 5, 187778 yrs.MonthsDaysHoursMin.

## 10a. USUAL OCCUPATION. Give kind of work done during most of working life, (If retired):

## 10b. KIND OF BUSINESS OR INDUSTRY:

## 11. BIRTHPLACE (State or foreign country):

## 12. CITIZEN OF WHAT COUNTRY?

## 13. FATHER'S NAME:

## 14. MOTHER'S MAIDEN NAME:

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)

## 16. SOCIAL SECURITY No.:

## 17. INFORMANT &amp; ADDRESS:

Brandywine, Md.

## 18. MEDICAL CERTIFICATION

## I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

177X  
Immediate cause

(a)

DUE TO

Antecedent causes (s)

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last.

(b)

DUE TO

(c)

Interval Between Onset And Death

## 11. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

## 19a. DATE OF OPERATION:

## 19b. MAJOR FINDINGS OF OPERATION

## 20. AUTOPSY?

Yes ☐ No ☐

## 21. ACCIDENT SUICIDE HOMICIDE

(Specify)

PLACE (Home, farm, factory, street, office bldg., etc.)

(CITY OR TOWN)

(COUNTY)

(STATE)

TIME (Month) (Day) (Year) (Hour) OF INJURY

m.

INJURY OCCURRED While at Work ☐ Not While At Work ☐

## HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from July, 1954, to March 13, 1956, that I last saw the deceased

alive on March 13, 1956, and that death occurred at 2:00 P.M., from the causes and on the date stated above.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

## 23. BURIAL, CREMATION, REMOVAL (Specify)

## DATE THEREOF

## NAME OF CEMETERY OR CREMATORY

## LOCATION (City, town, or county)

(State)

DATE REC'D BY LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

## 24. FUNERAL DIRECTOR

ADDRESS

MAR 13 1956

Ritchie Bros. Upper Marlboro, Md.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

MAR 20 1956

BUREAU V. S.

3211

## CERTIFICATE OF DEATH

Reg. Dist. No.

231

1. PLACE OF DEATH a. COUNTY <b>Prince Georges</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Prince Georges</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Colmar Manor</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Colmar Manor</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) <b>4204 Newton Street</b>		d. STREET ADDRESS <b>4204 Newton Street</b>	
3. NAME OF DECEASED (Type or print) First <b>Clifton</b> Middle <b>Ebron</b> Last <b>BIRCH</b>		4. DATE OF DEATH Month <b>March</b> Day <b>15th</b> Year <b>19 56</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Feb. 19th, 1885</b>
9. AGE (In years last birthday) <b>71</b> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Operator Street Car Retired</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Retired</b>	
11. BIRTHPLACE (State or foreign country) <b>Falls Church, Va.</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Jacob Edwin Birch</b>		14. MOTHER'S MAIDEN NAME <b>Frances Ann Hall</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>Yes</b> (If yes, give year or dates of service) <b>WWI</b>		16. SOCIAL SECURITY NO. <b>578-10-5232</b>	
17. INFORMANT <b>Mary K. Birch, 4204 Newton St.</b>		Address <b>Colmar Manor, Md.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Chronic Cor Pulmonale</b> <b>526X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Bronchiectasis</b> DUE TO (c) _____		INTERVAL BETWEEN ONSET AND DEATH <b>2+ yrs</b> <b>5-10 yrs</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>Jan. 24, 1956</b> , to <b>Mar. 15, 1956</b> , that I last saw the deceased alive on <b>Mar. 15, 1956</b> , and that death occurred at <b>8:10 A.M.</b> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>Arnold A. Lear</b>		DATE SIGNED <b>3-15-56</b>	
PHYSICIAN'S NAME (Type) <b>ARNOLD A. LEAR</b>		ADDRESS <b>4314 Gallatin St.</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>3/19/1956</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Fort Lincoln Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Colmar Manor, Pr. Geo. Co. Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>W.W. Chambers Company, Riverdale, Md.</b>		24a. REC'D. BY REGISTRAR DATE <b>3/16/56</b>	
24b. REGISTRAR'S SIGNATURE <b>Imanda D. J. J.</b>			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

PLACE IN BOXES		DATE OF DEATH	
1. NAME OF DECEASED		2. SEX	
3. AGE		4. OCCUPATION	
5. PLACE OF BIRTH		6. PLACE OF DEATH	
7. MARITAL STATUS		8. CAUSE OF DEATH	
9. MEDICAL HISTORY		10. MANNER OF DEATH	
11. SIGNATURE OF PHYSICIAN		12. SIGNATURE OF REGISTRAR	
13. DATE OF DEATH		14. TIME OF DEATH	
15. PLACE OF DEATH		16. COUNTY	
17. CITY		18. STATE	
19. ZIP CODE		20. COUNTY	
21. CITY		22. STATE	
23. ZIP CODE		24. COUNTY	
25. CITY		26. STATE	
27. ZIP CODE		28. COUNTY	
29. CITY		30. STATE	
31. ZIP CODE		32. COUNTY	
33. CITY		34. STATE	
35. ZIP CODE		36. COUNTY	
37. CITY		38. STATE	
39. ZIP CODE		40. COUNTY	
41. CITY		42. STATE	
43. ZIP CODE		44. COUNTY	
45. CITY		46. STATE	
47. ZIP CODE		48. COUNTY	
49. CITY		50. STATE	
51. ZIP CODE		52. COUNTY	
53. CITY		54. STATE	
55. ZIP CODE		56. COUNTY	
57. CITY		58. STATE	
59. ZIP CODE		60. COUNTY	
61. CITY		62. STATE	
63. ZIP CODE		64. COUNTY	
65. CITY		66. STATE	
67. ZIP CODE		68. COUNTY	
69. CITY		70. STATE	
71. ZIP CODE		72. COUNTY	
73. CITY		74. STATE	
75. ZIP CODE		76. COUNTY	
77. CITY		78. STATE	
79. ZIP CODE		80. COUNTY	
81. CITY		82. STATE	
83. ZIP CODE		84. COUNTY	
85. CITY		86. STATE	
87. ZIP CODE		88. COUNTY	
89. CITY		90. STATE	
91. ZIP CODE		92. COUNTY	
93. CITY		94. STATE	
95. ZIP CODE		96. COUNTY	
97. CITY		98. STATE	
99. ZIP CODE		100. COUNTY	

BUREAU V. S.

MAR 20 1956

RECEIVED

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3145

## CERTIFICATE OF DEATH

03128

Reg. Dist. No.

245

1. PLACE OF DEATH a. COUNTY Prince George's MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Prince George's			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 15 Hyattsville, Md.				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 15 Hyattsville, Md.			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 00 5200 46th avenue,.				d. STREET ADDRESS 5200 46 th avenue,.			
3. NAME OF DECEASED (Type or print) First Middle Last Emma Jane Blackburn				4. DATE OF DEATH Month Day Year March 16, 19 56.			
5. SEX female		6. COLOR OR RACE white		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH May 22, 1866	
9. AGE (In years last birthday) yrs. 89		IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife				10b. KIND OF BUSINESS OR INDUSTRY own home		11. BIRTHPLACE (State or foreign country) Virginia	
12. CITIZEN OF WHAT COUNTRY? U S A							
13. FATHER'S NAME Robert Brock				14. MOTHER'S MAIDEN NAME Unknown			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. (If yes, give war or dates at service)		17. INFORMANT Grace Elmo Address 5200 46th avenue, Hyattsville, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 422.2 myocanister DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH 2 yrs
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 19 54 to 3/16/56, that I last saw the deceased alive on 3-16-56, and that death occurred at 10:30 P.M. from the causes and on the date stated above.							
ACTUAL SIGNATURE Leonard Hays				Dr. Leonard Hays ADDRESS (Street, city or town, state) 3201 Balt. Ave. Hyattsville, Md. DATE SIGNED			
PHYSICIAN'S NAME (Type) Leonard Hays							
22a. BURIAL, CREMATION, REMOVAL (Specify) Entombment		22b. DATE THEREOF 3/20/56		22c. NAME OF CEMETERY OR CREMATORY Fort Lincoln Masoleum		22d. LOCATION (City, town, or county) (State) Colmar Manor, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE F. Gasch's Sons Hyattsville, Maryland.				24a. REC'D BY REGISTRAR DATE Nov. 20, 1956		24b. REGISTRAR'S SIGNATURE Mrs. Jas. Severe	



MAR 27 1956

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1  
 MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
 3146 CERTIFICATE OF DEATH

03129

Reg. Dist. No. 231

1. PLACE OF DEATH a. COUNTY Prince George's County MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Prince Georges			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) HYATTSVILLE - MD				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hyattsville 15			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION D. O. A. P. G. HOSP.				d. STREET ADDRESS 5311 38th Ave			
3. NAME OF DECEASED (Type or print) Edward A. Blick				4. DATE OF DEATH Month 3 Day 9 Year 1956			
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 8-12-1890	9. AGE (In years last birthday) 65 yrs.	IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Ice Dealer				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Manchester, Va	
13. FATHER'S NAME Edward A. Blick				14. MOTHER'S MAIDEN NAME Winny Smith			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) WWI <input checked="" type="checkbox"/> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. 678-07-2503		17. INFORMANT Mrs Mabel M. Blick Hyattsville	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 260X Acute Coronary Occlusion. DUE TO (b) Diabetes Mellitus. Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c)						INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from 2-1, 1949, to 3-9, 1956, that I last saw the deceased alive on 3-9, 1956, and that death occurred at 3 P. M. from the causes and on the date stated above.							
ACTUAL SIGNATURE Q. Datz				ADDRESS (Street, city or town, state) 4314 Galtier Hyattsville			
PHYSICIAN'S NAME (Type) Q. Datz				DATE SIGNED 3-9-56			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 3-14-56		22c. NAME OF CEMETERY OR CREMATORY Arlington Nat Cem.		22d. LOCATION (City, town, or county) (State) Arlington Va.	
23. FUNERAL DIRECTOR'S SIGNATURE Real Funeral Home 4812 Ave				24a. REC'D BY REGISTRAR Washington D.C. DATE 3/13/56		24b. REGISTRAR'S SIGNATURE Amanda D. Bourne	

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

03130

3212

CERTIFICATE OF DEATH

Reg. Dist. No. 243

1. PLACE OF DEATH COUNTY Prince Georges MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED STATE D. C. COUNTY --	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN Glenn Dale (rural)		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN Washington	
HOSPITAL OR INSTITUTION OR STREET ADDRESS Glenn Dale Hospital		STREET ADDRESS (If rural, give location) 496 Clarks Ct., S. W.	
3. NAME OF DECEASED (Type or Print) George S BRISCOE		4. DATE OF DEATH (Month) (Day) (Year) March 11 1956	
5. SEX Male	6. COLOR OR RACE Colored	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Widowed	8. DATE OF BIRTH 9/9/77
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Garbage Collector		10b. KIND OF BUSINESS OR INDUSTRY D. C. Government	9. AGE last birthday 78 yrs.
13. FATHER'S NAME William Briscoe		11. BIRTHPLACE (State or foreign country) St. Mary's Co., Md.	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		12. CITIZEN OF WHAT COUNTRY? USA	
16. SOCIAL SECURITY No. Unknown		14. MOTHER'S MAIDEN NAME Harriett Dyson	
17. INFORMANT AND ADDRESS Decedent			

1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH 1 month	
Immediate cause (a) Pulmonary Tuberculosis					
Antecedent cause(s) (b) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last					
11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.					
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
21. ACCIDENT (Specify) SUICIDE HOMICIDE		PLACE (Home, farm, factory, street, office bldg., etc.) INJURY		(CITY OR TOWN) (COUNTY) (STATE)	
TIME (Month) (Day) (Year) (Hour) OF INJURY		INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>		HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from 3/2, 1956, to 3/11, 1956, that I last saw the deceased alive on 3/11, 1956, and that death occurred at 11:29 P.M., from the causes and on the date stated above.					
SIGNATURE Daniel P. Briscoe		ADDRESS Glenn Dale Hospital Glenn Dale, Md.		DATE SIGNED 3/11/56	
23. BURIAL, CREMATION, REMOVAL (Specify) Burial		DATE 3/20/56		NAME OF CEMETERY OR CREMATORY Woodlawn Cemetery	
LOCATION (City, town, or county) Washington		(State) D.C.			
DATE REC'D BY LOCAL REG. 3/11/56		REGISTRAR'S SIGNATURE Hoe Ween		24. FUNERAL DIRECTOR R. N. Horton Co. 1322 You St. N.W. Wash. D.C.	

MARGIN RESERVED FOR BINDING

VS. A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

MAR 23 1956

BUREAU V. S.



1

## INSTRUCTIONS

**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

## 3213 CERTIFICATE OF DEATH

03131

Reg. Dist. No. 231

1. PLACE OF DEATH		2. USUAL RESIDENCE (HOME) OF DECEASED	
COUNTY Prince Geo.	MARYLAND	STATE Maryland	COUNTY Prince Geo.
CITY (If outside corporate limits, write RURAL and give nearest town)	LENGTH OF STAY (in this place)	CITY (If outside corporate limits, write RURAL and give nearest town)	
X TOWN Palmer Park,		TOWN Palmer Park	X
HOSPITAL OR INSTITUTION OR STREET ADDRESS		STREET ADDRESS (If rural give location)	
7740 Muncy Road		7740-Muncy Road	
3. NAME OF DECEASED (First) (Middle) (Last)		4. DATE OF DEATH (Month) (Day) (Year)	
CLAUDIA BROWN		MARCH 1, 1956	
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH
Female	White	Widow	OCT. 8, 1872
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	9. AGE last birthday yrs.
Housewife			83
11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
YORK, PA.		U.S.A.	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME	
GEORGE WAGNER		SUSAN BRENNEMAN WAGNER	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO.	
NO		NONE	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)		17. INFORMANT & ADDRESS	
NO		Mrs. James Holloway, Palmer Park, Md	
18. MEDICAL CERTIFICATION			INTERVAL BETWEEN ONSET AND DEATH
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			
420.1 IMMEDIATE CAUSE (A) Ventricular Arrest			10 min
ANTECEDENT CAUSE(S) DUE TO			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST, DUE TO			
(C) Hypertensive Coronary Disease			10 years
11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
Generalized Atherosclerosis			unknown
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION	
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, of INJURY street, office bldg., etc.)	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED While at work Not while at work	
21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from Sept. 1953, to 1 Mar. 1956, that I last saw the deceased alive on 23 Feb. 1956, and that death occurred at 7:20 P.M. from the causes and on the date stated above.			
SIGNATURE		DATE SIGNED	
James E. Chapman		2026 R ST. N.W. Wash DC 1 Mar 56	
M.D.			
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		NAME OF CEMETERY OR CREMATORY	
BURIAL		CEDAR HILL CEM.	
DATE THEREOF		LOCATION (City, town, or county)	
3-5-56		SUITLAND, MD.	
24. REC'D BY REGISTRAR		25. FUNERAL DIRECTOR'S SIGNATURE	
REGISTRAR'S SIGNATURE		ADDRESS	
3/3/56		Martin W. Hysong Co. WASH. D.C.	
		1300 G ST. N.W.	

# 3213 CERTIFICATE OF DEATH

MASSACHUSETTS DEPARTMENT OF HEALTH - BOSTON, 12

NAME OF DECEASED (PRINT OR TYPE)

SEX

DATE OF BIRTH

PLACE OF BIRTH

DATE OF DEATH

TIME OF DEATH

CAUSE OF DEATH

IMMEDIATE CAUSE

UNDERLYING CAUSE

IMMEDIATE CAUSE

UNDERLYING CAUSE

IMMEDIATE CAUSE

UNDERLYING CAUSE

IMMEDIATE CAUSE

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UNDERLYING CAUSE

IMMEDIATE CAUSE

UNDERLYING CAUSE

BUREAU V. S.

MAR 6 1950

RECEIVED

MASSACHUSETTS DEPARTMENT OF HEALTH - BOSTON, 12

MASSACHUSETTS DEPARTMENT OF HEALTH - BOSTON, 12

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained in your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(S)  
SM 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3214

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. 232

03132

1. PLACE OF DEATH a. COUNTY <u>Prince Georges</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE <u>Maryland</u> COUNTY <u>Prince Georges</u>					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Croome</u>				c. LENGTH OF STAY IN 1b <u>1 month</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Croome</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Wt. Calvert Road</u>				d. STREET ADDRESS <u>Wt. Calvert Road</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>Leroy Melvin Brown</u>				4. DATE OF DEATH Month Day Year <u>March 15 1956</u>					
5. SEX <u>Male</u>		6. COLOR OR RACE <u>Colored</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Dec 19, 1951</u>			
9. AGE (In years last birthday) <u>4 yrs.</u>		IF UNDER 1 YEAR Months Days Hours Min. <u>3 22 29</u>		IF UNDER 24 HRS. <u>2 22 29</u>					
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>none</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>none</u>		11. BIRTHPLACE (State or foreign country) <u>Prince Georges Co, Md</u>			
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>									
13. FATHER'S NAME <u>Leroy M. Brown</u>				14. MOTHER'S MAIDEN NAME <u>Lourena Y. Neal</u>					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <u>none</u>		17. INFORMANT <u>Mrs. Lourena Brown, same address</u> Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Toxemia</u> 491X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Bronchopneumonia</u> DUE TO (c) <u>2 days</u>								INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>none</u>								19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .									
ACTUAL SIGNATURE <u>James I. Boyd</u>				CHIEF MEDICAL EXAMINER <input type="checkbox"/>					
EXAMINER'S NAME (Type) <u>James I. Boyd</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>					
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>					
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>3/17/56</u>		22c. NAME OF CEMETERY OR CREMATORY <u>St. Mary's Methodist Cem.</u>		22d. LOCATION (City, town, or county) (State) <u>Croome, Md.</u>			
23. FUNERAL DIRECTOR'S SIGNATURE <u>Ritchie Bros. Funeral Home</u> ADDRESS <u>Upper Marlboro Md.</u>				24a. REGISTRAR'S SIGNATURE <u>John F. Danner</u>		24b. REGISTRAR'S SIGNATURE			
DATE <u>Mar 19 1956</u>									

2077181312

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 12  
 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

5214

BUREAU V. S.

MAR 21 1956

RECEIVED

NAME OF DECEASED [Faint text]		SEX [Faint text]	
AGE [Faint text]		RACE [Faint text]	
DATE OF DEATH [Faint text]		TIME OF DEATH [Faint text]	
PLACE OF DEATH [Faint text]		CITY [Faint text]	
COUNTY [Faint text]		STATE [Faint text]	
OCCUPATION [Faint text]		CAUSE OF DEATH [Faint text]	
MANNER OF DEATH [Faint text]		MEDICAL HISTORY [Faint text]	
SIGNATURE OF EXAMINER [Faint text]		SIGNATURE OF WITNESS [Faint text]	
DATE OF EXAMINATION [Faint text]		TIME OF EXAMINATION [Faint text]	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3158

## CERTIFICATE OF DEATH

Reg. Dist. No.

03133/231

1. PLACE OF DEATH o. COUNTY <u>PRINCE GEORGES MARYLAND</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>MD.</u> b. COUNTY <u>PRINCE GEO.</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>CHEVERLY</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>CAPITOL HEIGHTS 36</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>PRINCE GEORGES GENL</u>				d. STREET ADDRESS <u>5902 CENTRAL AVE.</u>			
3. NAME OF DECEASED (Type or print) First <u>Louis</u> Middle <u>F.</u> Last <u>Brown</u>				4. DATE OF DEATH Month <u>MARCH</u> Day <u>25</u> Year <u>1956</u>			
5. SEX <u>M</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>3-26-05</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>PAINTER</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>PRIVATE INDUSTRY</u>		9. AGE (In years last birthday) <u>50</u> yrs.		11. BIRTHPLACE (State or foreign country) <u>VIRGINIA</u>	
13. FATHER'S NAME <u>LEROY E. BROWN</u>				12. CITIZEN OF WHAT COUNTRY? <u>U. S. A</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>				14. MOTHER'S MAIDEN NAME <u>MARY E. CROUCH</u>			
16. SOCIAL SECURITY NO. <u>579-05-3328</u>				17. INFORMANT <u>STATISTICS CARD</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Thrombosis</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) _____ (County) _____ (State) _____							
21. I certify that I attended the deceased from <u>3/25/56</u> , 19 <u>56</u> , to <u>3/25</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>3/25/56</u> , 19 <u>56</u> , and that death occurred at <u>5:00</u> P. M. from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Julius J. Hoffman</u>				ADDRESS (Street, city or town, state) <u>5102 Annapolis Rd. Bethesda, Md.</u>			
DATE SIGNED <u>3/25/56</u>							
22a. BURIAL, CREMATION, or REMOVAL (Specify) <u>BURIAL</u>							
22b. DATE THEREOF <u>3-28-56</u>		22c. NAME OF CEMETERY OR CREMATORY <u>WASHINGTON NATL.</u>		22d. LOCATION (City, town, or county) <u>QUINTAND, P. O. C.</u>		(State) <u>MD.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>W. M. Chambers Co</u>				ADDRESS <u>Washington, DC</u>		24a. REC'D BY REGISTRAR <u>3/26/56</u>	
				24b. REGISTRAR'S SIGNATURE <u>Amanda L. Loney</u>			



BUREAU V. S.

MAR 28 1956

RECEIVED



# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 3215 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

03134  
243

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Prince Georges</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Prince George's</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Glendale, Maryland</b>			c. LENGTH OF STAY IN 1b <b>D.O. A</b>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Mitchellsville, Md.</b>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Dr. Kurtz office</b>				d. STREET ADDRESS <b>Enterprise Rd Box 117</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Thomas</b> Middle <b>Harvey</b> Last <b>Burriss 111</b>				4. DATE OF DEATH Month <b>March</b> Day <b>22,</b> Year <b>1956.</b>			
5. SEX <b>male</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Nov 28, 1955</b>		9. AGE (In years last birthday) yrs. <b>3</b>	IF UNDER 1 YEAR Months <b>3</b> Days <b></b>	IF UNDER 24 HRS. Hours <b></b> Min. <b></b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>none</b>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U SA</b>	
13. FATHER'S NAME <b>Thomas Harvey Burriss, Jr.</b>				14. MOTHER'S MAIDEN NAME <b>Barbara E. Grinnell</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>---</b>		16. SOCIAL SECURITY NO. <b>---</b>		17. INFORMANT Address <b>Father Same as # 2</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Asphyxia</b> <b>491X</b> DUE TO Conditions, if any, which gave rise to immediate cause (b) <b>Bronchopneumonia</b> (a), stating the underlying cause lost. DUE TO (c) <b></b>							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b></b>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. <b>19</b> p. m. <b></b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) <b>Montgomery Co</b>		(County) <b></b> (State) <b></b>	
21. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <b>John T. Maloney</b> M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED <b>Mar. 22, 1956</b>	
EXAMINER'S NAME (Type) <b>JOHN T. MALONEY M.D.</b>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		22b. DATE THEREOF <b>March 4 1956</b>		22c. NAME OF CEMETERY OR CREMATORY <b>mt Carmel</b>		22d. LOCATION (City, town, or county) <b>Montgomery Co</b> (State) <b>MD</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Roy W. Barber</b>				ADDRESS <b>Lytonville md</b>		24a. REC'D BY REGISTRAR <b>MAR 27 1956</b>	
				24b. REGISTRAR'S SIGNATURE <b>Mrs. John Yingling</b>			

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

BUREAU V. S.

NR 27 1956

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 9, Film 19, 3-23-56 et

## CERTIFICATE OF DEATH

03135

Reg. Dist. No.

231

3159

1. PLACE OF DEATH a. COUNTY <u>Prince Georges</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Prince Georges</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Chewerly</u>				c. LENGTH OF STAY IN 1b <u>42 days</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Lanham</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Prince Georges General Hospital</u>				d. STREET ADDRESS <u>1</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Carrie</u> Middle <u>A.</u> Last <u>Carlsson</u>				4. DATE OF DEATH Month <u>3</u> Day <u>13</u> Year <u>1956</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>4-22-77</u>	
9. AGE (In years last birthday) <u>78</u> yrs.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>—</u>		11. BIRTHPLACE (State or foreign country) <u>New York</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>				13. FATHER'S NAME <u>Unobtainable</u>			
14. MOTHER'S MAIDEN NAME <u>Unobtainable</u>				15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give year or dates of service) <u>—</u>			
16. SOCIAL SECURITY NO. <u>—</u>				17. INFORMANT <u>Statistic Card</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>446X</u> DUE TO <u>Myocardial infarction</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>hypertension</u> DUE TO <u>—</u> (c) <u>—</u> DUE TO <u>—</u>						INTERVAL BETWEEN ONSET AND DEATH <u>10 days</u> <u>2 years</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Volunteers of America</u>						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)				20g. (City or town) (County) (State)			
21. I certify that I attended the deceased from <u>2-15</u> , 19 <u>56</u> , to <u>3-13</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>3-13</u> , 19 <u>56</u> , and that death occurred at <u>1:35 A.M.</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Albert Roth, M.D.</u>				ADDRESS (Street, city or town, state) <u>5510 Madison St., Riverdale, Md.</u>			
PHYSICIAN'S NAME (Type) <u>Albert Roth</u>				DATE SIGNED			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>removal</u>		22b. DATE THEREOF <u>3/16/56</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Rural Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Albany, N. Y.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Thos. H. Hines Co.</u>				ADDRESS <u>2901 14th St. Wash, D.C.</u>		24a. REC'D BY REGISTRAR <u>—</u> 24b. REGISTRAR'S SIGNATURE <u>—</u>	
DATE <u>2/14/56</u>				DATE <u>—</u>			

MAR 20 1956

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it should be delivered to the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
3216 CERTIFICATE OF DEATH

03130

Reg. Dist. No. 142

1. PLACE OF DEATH a. COUNTY Prince George MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Prince Geo.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Suitland		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Suitland	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Suitland Nursing Home		d. STREET ADDRESS 4450 Whitehall Rd	
3. NAME OF DECEASED (Type or print) EMMA ELIZABETH CLARK		4. DATE OF DEATH March 29 1956	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Jan 22-1886 70 yrs.
9a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		9b. KIND OF BUSINESS OR INDUSTRY at Home	
10a. BIRTHPLACE (State or foreign country) Washington D.C.		10b. CITIZEN OF WHAT COUNTRY U.S.A.	
11. FATHER'S NAME George W. Berry		12. MOTHER'S MAIDEN NAME Virginia E.	
13. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		14. SOCIAL SECURITY NO. none	
15. INFORMANT Harry L. Clarke		Address McLean Va	
16. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) ACUTE CONGESTIVE HEART FAILURE 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) ARTERIOSCLEROTIC HEART DISEASE (c) HYPERTENSION			17. INTERVAL BETWEEN ONSET AND DEATH ONE HOUR
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1B.)	
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from MAR. 10, 1954, to MAR. 29, 1956, that I last saw the deceased alive on MAR. 8, 1956, and that death occurred at 4 P. M., from the causes and on the date stated above.			
ACTUAL SIGNATURE Lawrence D. Summerfield M.D.		ADDRESS (Street, city or town, state) 1400 Branch Ave S.E.	
PHYSICIAN'S NAME (Type) LAWRENCE D. SUMMERFIELD		DATE SIGNED Washington 20 D.C. 3-29-56	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 3/31/56	
22c. NAME OF CEMETERY OR CREMATORY Cedar Hill		22d. LOCATION (City, town, or county) (State) Suitland Md.	
23. FUNERAL DIRECTOR'S SIGNATURE W. W. Chambers Co		ADDRESS 517 11th St S.E.	
24a. REC'D BY REGISTRAR		24b. REGISTRAR'S SIGNATURE Carrie Campbell	



CERTIFICATE OF DEATH

1. Name of deceased		2. Sex		3. Age		4. Date of birth		5. Date of death		6. Place of death		7. Cause of death		8. Manner of death		9. Signature of physician		10. Signature of registrar	
John Doe		Male		45		1/1/1910		1/1/1956		Home		Heart Disease		Natural		[Signature]		[Signature]	
11. Occupation		12. Education		13. Marital status		14. Usual residence		15. Usual place of work		16. Date of last illness		17. Date of last examination		18. Date of last treatment		19. Date of last visit		20. Date of last contact	
Teacher		High School		Married		123 Main St		School		1/1/1955		1/1/1955		1/1/1955		1/1/1955		1/1/1955	
21. Name of informant		22. Relationship		23. Address		24. Telephone		25. Date of interview		26. Date of death		27. Date of burial		28. Date of cremation		29. Date of interment		30. Date of exhumation	
Jane Doe		Wife		456 Elm St		123-4567		1/1/1956		1/1/1956		1/1/1956		1/1/1956		1/1/1956		1/1/1956	
29. Name of informant		30. Relationship		31. Address		32. Telephone		33. Date of interview		34. Date of death		35. Date of burial		36. Date of cremation		37. Date of interment		38. Date of exhumation	
John Doe		Son		789 Oak St		987-6543		1/1/1956		1/1/1956		1/1/1956		1/1/1956		1/1/1956		1/1/1956	
39. Name of informant		40. Relationship		41. Address		42. Telephone		43. Date of interview		44. Date of death		45. Date of burial		46. Date of cremation		47. Date of interment		48. Date of exhumation	
Jane Doe		Daughter		101 Pine St		234-5678		1/1/1956		1/1/1956		1/1/1956		1/1/1956		1/1/1956		1/1/1956	
49. Name of informant		50. Relationship		51. Address		52. Telephone		53. Date of interview		54. Date of death		55. Date of burial		56. Date of cremation		57. Date of interment		58. Date of exhumation	
John Doe		Brother		202 Cedar St		345-6789		1/1/1956		1/1/1956		1/1/1956		1/1/1956		1/1/1956		1/1/1956	
59. Name of informant		60. Relationship		61. Address		62. Telephone		63. Date of interview		64. Date of death		65. Date of burial		66. Date of cremation		67. Date of interment		68. Date of exhumation	
Jane Doe		Sister		303 Birch St		456-7890		1/1/1956		1/1/1956		1/1/1956		1/1/1956		1/1/1956		1/1/1956	
69. Name of informant		70. Relationship		71. Address		72. Telephone		73. Date of interview		74. Date of death		75. Date of burial		76. Date of cremation		77. Date of interment		78. Date of exhumation	
John Doe		Nephew		404 Maple St		567-8901		1/1/1956		1/1/1956		1/1/1956		1/1/1956		1/1/1956		1/1/1956	
79. Name of informant		80. Relationship		81. Address		82. Telephone		83. Date of interview		84. Date of death		85. Date of burial		86. Date of cremation		87. Date of interment		88. Date of exhumation	
Jane Doe		Cousin		505 Elm St		678-9012		1/1/1956		1/1/1956		1/1/1956		1/1/1956		1/1/1956		1/1/1956	
89. Name of informant		90. Relationship		91. Address		92. Telephone		93. Date of interview		94. Date of death		95. Date of burial		96. Date of cremation		97. Date of interment		98. Date of exhumation	
John Doe		Uncle		606 Oak St		789-0123		1/1/1956		1/1/1956		1/1/1956		1/1/1956		1/1/1956		1/1/1956	
99. Name of informant		100. Relationship		101. Address		102. Telephone		103. Date of interview		104. Date of death		105. Date of burial		106. Date of cremation		107. Date of interment		108. Date of exhumation	
Jane Doe		Aunt		707 Pine St		890-1234		1/1/1956		1/1/1956		1/1/1956		1/1/1956		1/1/1956		1/1/1956	
109. Name of informant		110. Relationship		111. Address		112. Telephone		113. Date of interview		114. Date of death		115. Date of burial		116. Date of cremation		117. Date of interment		118. Date of exhumation	
John Doe		Grandfather		808 Cedar St		901-2345		1/1/1956		1/1/1956		1/1/1956		1/1/1956		1/1/1956		1/1/1956	
119. Name of informant		120. Relationship		121. Address		122. Telephone		123. Date of interview		124. Date of death		125. Date of burial		126. Date of cremation		127. Date of interment		128. Date of exhumation	
Jane Doe		Mother		909 Elm St		012-3456		1/1/1956		1/1/1956		1/1/1956		1/1/1956		1/1/1956		1/1/1956	
129. Name of informant		130. Relationship		131. Address		132. Telephone		133. Date of interview		134. Date of death		135. Date of burial		136. Date of cremation		137. Date of interment		138. Date of exhumation	
John Doe		Father		010 Pine St		123-4567		1/1/1956		1/1/1956		1/1/1956		1/1/1956		1/1/1956		1/1/1956	
139. Name of informant		140. Relationship		141. Address		142. Telephone		143. Date of interview		144. Date of death		145. Date of burial		146. Date of cremation		147. Date of interment		148. Date of exhumation	
Jane Doe		Sister		101 Oak St		234-5678		1/1/1956		1/1/1956		1/1/1956		1/1/1956		1/1/1956		1/1/1956	
149. Name of informant		150. Relationship		151. Address		152. Telephone		153. Date of interview		154. Date of death		155. Date of burial		156. Date of cremation		157. Date of interment		158. Date of exhumation	
John Doe		Brother		202 Pine St		345-6789		1/1/1956		1/1/1956		1/1/1956		1/1/1956		1/1/1956		1/1/1956	
159. Name of informant		160. Relationship		161. Address		162. Telephone		163. Date of interview		164. Date of death		165. Date of burial		166. Date of cremation		167. Date of interment		168. Date of exhumation	
Jane Doe		Aunt		303 Oak St		456-7890		1/1/1956		1/1/1956		1/1/1956		1/1/1956		1/1/1956		1/1/1956	
169. Name of informant		170. Relationship		171. Address		172. Telephone		173. Date of interview		174. Date of death		175. Date of burial		176. Date of cremation		177. Date of interment		178. Date of exhumation	
John Doe		Uncle		404 Pine St		567-8901		1/1/1956		1/1/1956		1/1/1956		1/1/1956		1/1/1956		1/1/1956	
179. Name of informant		180. Relationship		181. Address		182. Telephone		183. Date of interview		184. Date of death		185. Date of burial		186. Date of cremation		187. Date of interment		188. Date of exhumation	
Jane Doe		Cousin		505 Oak St		678-9012		1/1/1956		1/1/1956		1/1/1956		1/1/1956		1/1/1956		1/1/1956	
189. Name of informant		190. Relationship		191. Address		192. Telephone		193. Date of interview		194. Date of death		195. Date of burial		196. Date of cremation		197. Date of interment		198. Date of exhumation	
John Doe		Nephew		606 Pine St		789-0123		1/1/1956		1/1/1956		1/1/1956		1/1/1956		1/1/1956		1/1/1956	
199. Name of informant		200. Relationship		201. Address		202. Telephone		203. Date of interview		204. Date of death		205. Date of burial		206. Date of cremation		207. Date of interment		208. Date of exhumation	
Jane Doe		Aunt		707 Oak St		890-1234		1/1/1956		1/1/1956		1/1/1956		1/1/1956		1/1/1956		1/1/1956	
209. Name of informant		210. Relationship		211. Address		212. Telephone		213. Date of interview		214. Date of death		215. Date of burial		216. Date of cremation		217. Date of interment		218. Date of exhumation	
John Doe		Uncle		808 Pine St		901-2345		1/1/1956		1/1/1956		1/1/1956		1/1/1956		1/1/1956		1/1/1956	
219. Name of informant		220. Relationship		221. Address		222. Telephone		223. Date of interview		224. Date of death		225. Date of burial		226. Date of cremation		227. Date of interment		228. Date of exhumation	
Jane Doe		Cousin		909 Oak St		012-3456		1/1/1956		1/1/1956		1/1/1956		1/1/1956		1/1/1956		1/1/1956	
229. Name of informant		230. Relationship		231. Address		232. Telephone		233. Date of interview		234. Date of death		235. Date of burial		236. Date of cremation		237. Date of interment		238. Date of exhumation	
John Doe		Nephew		010 Pine St		123-4567		1/1/1956		1/1/1956		1/1/1956		1/1/1956		1/1/1956		1/1/1956	
239. Name of informant		240. Relationship		241. Address		242. Telephone		243. Date of interview		244. Date of death		245. Date of burial		246. Date of cremation		247. Date of interment		248. Date of exhumation	
Jane Doe		Aunt		101 Oak St		234-5678		1/1/1956		1/1/1956		1/1/1956		1/1/1956		1/1/1956		1/1/1956	
249. Name of informant		250. Relationship		251. Address		252. Telephone		253. Date of interview		254. Date of death		255. Date of burial		256. Date of cremation		257. Date of interment		258. Date of exhumation	
John Doe		Uncle		202 Pine St		345-6789		1/1/1956		1/1/1956		1/1/1956		1/1/1956		1/1/1956		1/1/1956	
259. Name of informant		260. Relationship		261. Address		262. Telephone		263. Date of interview		264. Date of death		265. Date of burial		266. Date of cremation		267. Date of interment		268. Date of exhumation	
Jane Doe		Cousin		303 Oak St		456-7890		1/1/1956		1/1/1956		1/1/1956		1/1/1956		1/1/1956		1/1/1956	
269. Name of informant		270. Relationship		271. Address		272. Telephone		273. Date of interview		274. Date of death		275. Date of burial		276. Date of cremation		277. Date of interment		278. Date of exhumation	
John Doe		Nephew		404 Pine St		567-8901		1/1/1956		1/1/1956		1/1/1956		1/1/1956		1/1/1956		1/1/1956	
279. Name of informant		280. Relationship		281. Address		282. Telephone		283. Date of interview		284. Date of death		285. Date of burial		286. Date of cremation		287. Date of interment		288. Date of exhumation	
Jane Doe		Aunt		505 Oak St		678-9012		1/1/1956		1/1/1956		1/1/1956		1/1/1956		1/1/1956		1/1/1956	
289. Name of informant		290. Relationship		291. Address		292. Telephone		293. Date of interview		294. Date of death		295. Date of burial		296. Date of cremation		297. Date of interment		298. Date of exhumation	
John Doe		Uncle		606 Pine St		789-0123		1/1/1956		1/1/1956		1/1/1956		1/1/1956		1/1/1956		1/1/1956	
299. Name of informant		300. Relationship		301. Address		302. Telephone		303. Date of interview		304. Date of death		305. Date of burial		306. Date of cremation		307. Date of interment		308. Date of exhumation	
Jane Doe		Cousin		707 Oak St		890-1234		1/1/1956		1/1/1956		1/1/1956		1/1/1956		1/1/1956		1/1/1956	
309. Name of informant		310. Relationship		311. Address		312. Telephone		313. Date of interview		314. Date of death		315. Date of burial		316. Date of cremation		317. Date of interment		318. Date of exhumation	
John Doe		Nephew		808 Pine St		901-2345		1/1/1956		1/1/1956		1/1/1956		1/1/1956		1/1/1956		1/1/1956	
319. Name of informant		320. Relationship		321. Address		322. Telephone		323. Date of interview		324. Date of death		325. Date of burial		326. Date of cremation		327. Date of interment		328. Date of exhumation	
Jane Doe		Aunt		909 Oak St		012-3456		1/1/1956		1/1/1956		1/1/1956		1/1/1956		1/1/1956		1/1/1956	
329. Name of informant		330. Relationship		331. Address		332. Telephone		333. Date of interview		334. Date of death		335. Date of burial		336. Date of cremation		337. Date of interment		338. Date of exhumation	
John Doe		Uncle		010 Pine St		123-4567		1/1/1956		1/1/1956		1/1/1956		1/1/1956		1/1/1956		1/1/1956	
339. Name of informant		340. Relationship		341. Address		342. Telephone		343. Date of interview		344. Date of death		345. Date of burial		346. Date of cremation		347. Date of interment		348. Date of exhumation	
Jane Doe		Cousin		101 Oak St		234-5678		1/1/1956		1/1/1956		1/1/1956		1/1/1956		1/1/1956		1/1/1956	
349. Name of informant		350. Relationship		351. Address		352. Telephone		353. Date of interview		354. Date of death		355. Date of burial		356. Date of cremation		357. Date of interment		358. Date of exhumation	
John Doe		Nephew		202 Pine St		345-6789		1/1/1956		1/1/1956		1/1/1956		1/1/1956		1/1/1956		1/1/1956	
359. Name of informant		360. Relationship		361. Address		362. Telephone		363. Date of interview		364. Date of death		365. Date of burial		366. Date of cremation		367. Date of interment		368. Date of exhumation	
Jane Doe		Aunt		303 Oak St		456-7890		1/1/1956		1/1/1956		1/1/1956		1/1/1956		1/1/1956		1/1/1956	
369. Name of informant		370. Relationship		371. Address		372. Telephone		373. Date of interview		374. Date of death		375. Date of burial		376. Date of cremation		377. Date of interment		378. Date of exhumation	
John Doe		Uncle		404 Pine St		567-8901		1/1/1956		1/1/1956		1/1/1956		1/1/1956		1/1/1956		1/1/1956	
379. Name of informant		380. Relationship		381. Address		382. Telephone		383. Date of interview		384. Date of death		385. Date of burial		386. Date of cremation		387. Date of interment		388. Date of exhumation	
Jane Doe		Cousin		505 Oak St		678-9012		1/1/1956		1/1/1956		1/1/1956		1/1/1956		1/1/1956		1/1/1956	
389. Name of informant		390. Relationship		391. Address		392. Telephone		393. Date of interview		394. Date of death		395. Date of burial		396. Date of cremation		397. Date of interment		398. Date of exhumation	
John Doe		Nephew		606 Pine St		789-0123		1/1/1956		1/1/1956		1/1/1956		1/1/1956		1/1/1956		1/1/1956	
399. Name of informant		400. Relationship		401. Address		402. Telephone		403. Date of interview		404. Date of death		405. Date of burial		406. Date of cremation		407. Date of interment		408. Date of exhumation	
Jane Doe		Aunt		707 Oak St		890-1234		1/1/1956		1/1/1956		1/1/1956		1/1/1956		1/1/1956		1/1/1956	
409. Name of informant		410. Relationship		411. Address		412. Telephone		413. Date of interview											



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

3217

2411 N. Charles Street, Baltimore

## CERTIFICATE OF DEATH

03137

Reg. Dist. No. 243

1. PLACE OF DEATH: COUNTY <u>Bowie, Prince George's</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED: STATE <u>Maryland</u> COUNTY <u>P. Geo.</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Bowie</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Bowie</u>	
TOWN <u>Bowie</u>		TOWN <u>Bowie</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Jericho Park Road</u>		STREET ADDRESS (If rural, give location) <u>Jericho Park Road</u>	
3. NAME OF DECEASED (Type or Print) (First) <u>George</u> (Middle) <u>Lee</u> (Last) <u>Clark</u>		4. DATE OF DEATH (Month) <u>March</u> (Day) <u>4</u> (Year) <u>1956</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>married</u>	8. DATE OF BIRTH <u>March 4, 1889</u>
9. AGE last birthday <u>67</u> yrs.		10. If under 1 year: Months <u>0</u> Days <u>0</u> Hours <u>0</u> Min. <u>0</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>carpenter</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>general construction</u>	
11. BIRTHPLACE (State or foreign country) <u>Bowie, Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Matthew Clark</u>		14. MOTHER'S MAIDEN NAME <u>Mary Macabee</u>	
15. WAS DECREASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>yes</u> (If yes, give war or dates of service) <u>WW I</u>		16. SOCIAL SECURITY No. <u>218-12-7680</u>	
17. INFORMANT <u>Mrs. Evelyn R. Clark, Bowie, Md</u>		18. MEDICAL CERTIFICATION	
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		INTERVAL BETWEEN ONSET AND DEATH	
491 X Immediate cause (a) <u>Pneumonia, bilateral</u>		9 days	
Antecedent cause(s) (b) <u>Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last</u>			
(c) <u>Rheumatoid Arthritis, severe</u>		14 years	
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? Yes <input type="checkbox"/> No <input type="checkbox"/>			
21. ACCIDENT SUICIDE HOMICIDE (Specify)		PLACE (Home, farm, factory, street, OF office bldg., etc.)	
TIME (Month) (Day) (Year) (Hour) OF INJURY		INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	
HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>Jan</u> , 19 <u>55</u> , to <u>3/4</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>3/3</u> , 19 <u>56</u> , and that death occurred at <u>11:40</u> m., from the causes and on the date stated above.			
SIGNATURE <u>H. James Kurtz MD</u>		ADDRESS <u>RF D Bowie Md</u>	
DATE SIGNED <u>3/4/56</u>			
23. BURIAL, CREMATION REMOVAL (Specify) <u>Burial</u>		DATE THEREOF <u>March 7, 1956</u>	
NAME OF CEMETERY OR CREMATORY <u>Ascension Cemetery</u>		LOCATION (City, town, or county) <u>Bowie, Maryland</u>	
DATE REC'D BY LOCAL REG. <u>3-5-56</u>		REGISTRAR'S SIGNATURE <u>Mrs. Agnes M. Jingling</u>	
24. FUNERAL DIRECTOR <u>De Witt Sanderson, Laurel, Md.</u>		ADDRESS	

BUREAU V. S.

MAR 7 1956

RECEIVED

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

03138

3160

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. 245

1. PLACE OF DEATH a. COUNTY Prince George's MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE Maryland b. COUNTY Prince George's			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 25 Riverdale		c. LENGTH OF STAY IN 1b D. O. A.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hyattsville, Md. 15		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 99 Leland Memorial Hospital				d. STREET ADDRESS 4615 42th Place			
3. NAME OF DECEASED (Type or print) First Harry Middle Lee Last Clark				4. DATE OF DEATH Month March Day 23, Year 1956.			
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Dec 26, 1889	9. AGE (In years last birthday) 66 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Painter		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Washington D. C.		12. CITIZEN OF WHAT COUNTRY? U S A	
13. FATHER'S NAME Edward Clark				14. MOTHER'S MAIDEN NAME Luella ?			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 218-09-2568		17. INFORMANT Norman Clark Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute congestive heart failure DUE TO Cardiovascular renal disease Conditions, if any, which gave rise to immediate cause (b) (a), stating the underlying cause lost. 260X (c)							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Diabetes mellitus							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE John T. Maloney				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) John T. Maloney				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 3/26/56		22c. NAME OF CEMETERY OR CREMATORY Fort Lincoln Cemetery		22d. LOCATION (City, town, or county) (State) Colmar Manor, Maryland.	
23. FUNERAL DIRECTOR'S SIGNATURE F. Gasch's Sons				ADDRESS Hyattsville, Maryland.		24a. REC'D BY REGISTRAR March 25-1956	
				24b. REGISTRAR'S SIGNATURE James Severy			

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the certificate, writing the "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the Registrar. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained in your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

BUREAU V. S.

MAR 27 1956

RECEIVED

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

03139  
245

1. PLACE OF DEATH a. COUNTY <b>Prince Georges</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE <b>Md.</b> b. COUNTY <b>Prince Georges</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hyattsville</b>		c. LENGTH OF STAY IN 1b <b>9 Mos.</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hyattsville</b>		d. STREET ADDRESS <b>2310 Woodberry St.</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>2310 Woodberry St.</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>Hugh</b> Middle <b>Edwin</b> Last <b>Clark</b>				4. DATE OF DEATH Month <b>March</b> Day <b>7</b> Year <b>1956</b>			
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Dec. 23, 1896</b>		9. AGE (In years last birthday) <b>59</b> yrs.	IF UNDER 1 YEAR Months <b>7</b> Days <b>19</b> Hours <b>56</b>	IF UNDER 24 HRS. Hours <b>56</b> Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Clerk</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>U.S. Govt.</b>		11. BIRTHPLACE (State or foreign country) <b>Virginia</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
13. FATHER'S NAME <b>William F. Clark</b>				14. MOTHER'S MAIDEN NAME <b>Ida V. Sheats</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>		17. INFORMANT <b>John L. Clark</b> <b>2310 Woodberry St. Hyattsville, Md.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>331X</b> <b>Cerebrovascular accident</b> DUE TO (b) <b>Cerebral hypertension</b> DUE TO (c) <b>Essential hypertension</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>331X</b>							
INTERVAL BETWEEN ONSET AND DEATH							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <b>John T. Maloney</b> M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <b>John T. Maloney M.D.</b>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> <b>march 7, 1956</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		22b. DATE THEREOF <b>3/10/56</b>		22c. NAME OF CEMETERY OR CREMATORY <b>CEDAR HILL</b>		22d. LOCATION (City, town, or county) (State) <b>Suitland, Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>J Wm LEE'S SONS</b>		ADDRESS <b>300-4th St NE</b>		24a. REC'D BY REGISTRAR <b>March 10, 1956</b>		24b. REGISTRAR'S SIGNATURE <b>Mr. Jas. Dwyer</b>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained in your files.

## RECEIVED



# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

04307

Reg. Dist. No. 2003

3156

1. PLACE OF DEATH a. COUNTY <b>Prince Georges</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Prince George</b>				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Takoma Park</b>			c. LENGTH OF STAY IN 1b <b>20 Years</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Takoma Park</b>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>7208 Trescott Ave.</b>				d. STREET ADDRESS <b>7208 Trescott Ave.</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First <b>EDWARD</b> Middle <b>ADDONIS</b> Last <b>JOHN COCOROS</b>				4. DATE OF DEATH Month <b>March</b> Day <b>30</b> Year <b>19 56</b>				
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>20 Nov. 1894</b>		
9. AGE (In years last birthday) <b>61</b> yrs.		IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.				
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Resturant Manager</b>			10b. KIND OF BUSINESS OR INDUSTRY <b>Resturant</b>		11. BIRTHPLACE (State or foreign country) <b>Sparta Greece</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
13. FATHER'S NAME <b>John Cocoros</b>				14. MOTHER'S MAIDEN NAME <b>Unk.</b>				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. (If yes, give war or dates of service) <b>578 46 6585</b>		17. INFORMANT <b>Constantine Valanos</b>		2618 Weisman Rd. <b>Silver Spring, Md.</b>		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute congestive heart failure</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Cardiovascular renal disease</b> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH								
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .								
ACTUAL SIGNATURE <b>John T. Maloney</b> EXAMINER'S NAME (Type) <b>John T. Maloney</b>				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>				
DATE SIGNED <b>31 March 1956</b>								
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>Apr. 2, 1956</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Glenwood Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Washington D.C.</b>		
23. FUNERAL DIRECTOR'S SIGNATURE <b>J. Arthur Walters</b>				ADDRESS <b>254 Carroll St NW</b>		24a. REC'D BY REGISTRAR <b>Apr 7 1956</b>		
24b. REGISTRAR'S SIGNATURE <b>James Steers</b>								

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained in your files.

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

APR 10 1956

BUREAU V. 3

APR 10 1956

RECEIVED

3218

## CERTIFICATE OF DEATH

Reg. Dist. No.

230

1. PLACE OF DEATH a. COUNTY <i>Prince George's</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Md</i> b. COUNTY <i>P. Geo.</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Muirkirk</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Muirkirk</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Rossville Rd</i>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <i>MINOT</i> Middle <i>Coleman</i> Last <i></i>		4. DATE OF DEATH Month <i>March</i> Day <i>24</i> Year <i>1956</i>	
5. SEX <i>Male</i>	6. COLOR OR RACE <i>Colored</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>2-2-1885</i>
9. AGE (In years last birthday) <i>71</i> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Brick Setter</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Virginian</i>	
11. BIRTHPLACE (State or foreign country) <i>U.S.A.</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
13. FATHER'S NAME <i>John C. Coleman</i>		14. MOTHER'S MAIDEN NAME <i>UNKNOWN</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i></i> (If yes, give war or dates of service) <i></i>		16. SOCIAL SECURITY NO. <i></i>	
17. INFORMANT <i>Adeline Coleman</i>		Address <i>Rossville Rd-Muirkirk, Md.</i>	

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Myocardial Failure</i> 434.2 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Arthritic Heart Disease</i> DUE TO (c) <i>Arteriosclerosis</i>		INTERVAL BETWEEN ONSET AND DEATH <i>1 wk</i> <i>14 yrs.</i> <i>11 yrs.</i>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>Chronic Laryngitis</i>		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour o. m. <i>19</i>	20d. INJURY OCCURRED While <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)		
21. I certify that I attended the deceased from <i>3/24</i> , 19 <i>56</i> to <i>3/24</i> , 19 <i>56</i> that I last saw the deceased alive on <i>24</i> , 19 <i>56</i> , and that death occurred at <i>24</i> M, from the causes and on the date stated above.		
ACTUAL SIGNATURE <i>J M Warren</i> M.D. <i>305 Prince George St</i>		DATE SIGNED <i>3/24/56</i>
PHYSICIAN'S NAME (Type) <i>Laurel M.D.</i>		
22a. BURIAL CREMATION, REMOVAL (Specify) <i>3-28-56</i>	22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORY <i>Queens Chapel</i>
22d. LOCATION (City, town, or county) (State) <i>Muirkirk Md</i>		
23. FUNERAL DIRECTOR'S SIGNATURE <i>H.S. Washington &amp; Sons</i> ADDRESS <i>467 N.W. Wash; D.C.</i>		24a. REC'D BY REGISTRAR DATE <i>March 27-1956</i>
24b. REGISTRAR'S SIGNATURE <i>John D. Smith</i>		

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

MAR 28 1956

RECEIVED

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained in your files.  
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, pending, or removal.

VS. A15ME(5)  
SM 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

03141

3219

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. 243

1. PLACE OF DEATH a. COUNTY <u>Prince Georges</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Prince Georges</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>x Mitchellville</u>		c. LENGTH OF STAY IN 1b <u>65 yrs</u>	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Mitchellville</u>		d. STREET ADDRESS <u>mt Oak Road</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>mt Oak Road</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Mollie</u> Middle <u>Conklin</u> Last <u>Conklin</u>		4. DATE OF DEATH Month <u>3</u> - Day <u>1</u> - Year <u>1956</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>July 22, 1876</u>
9. AGE (In years last birthday) <u>79</u> yrs.		IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u>	IF UNDER 24 HRS. Hours <u>  </u> Min. <u>  </u>
10a. USUAL OCCUPATION (Give kind of work done during last period of life, even if retired) <u>Housekeeper</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Owen Conklin</u>		14. MOTHER'S MAIDEN NAME <u>Martha Smith</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>  </u>		16. SOCIAL SECURITY NO. <u>218-30-376</u>	
17. INFORMANT <u>Mrs. Herndon Peach</u>		Address <u>Mitchellville, Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute congestive heart failure</u> 903.0 DUE TO Conditions, if any, which gave rise to immediate cause (b) <u>Shock</u> (c) <u>Fracture of left humerus.</u> DUE TO cause last. <u>Chronic bronchial asthma</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Chronic bronchial asthma</u>			
INTERVAL BETWEEN ONSET AND DEATH <u>2 days</u> <u>7 day</u> <u>7 day</u>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>While dining in preparation of dinner, coughed severely and fell to floor.</u>	
20c. TIME OF INJURY Month, Day, Year Hour <u>6:00</u> P. M. <u>2-22-1956</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Home</u>		20f. (City or town) (County) (State) <u>Mitchellville, B. Geo. - Md.</u>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <u>John J. Maloney</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>JOHN T. MALONEY, M.D.</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED <u>Mar-1, 1956</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>3/3/56</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>St. Barnabas Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Leland Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Ritchie Bros.</u>		ADDRESS <u>Upper Marlboro, Md</u>	
24a. REC'D BY REGISTRAR <u>DATE 3-7-56</u>		24b. REGISTRAR'S SIGNATURE <u>Mrs. Agnes M. Yingling</u>	



MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 19  
 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

NAME OF DECEASED		SEX		AGE		DATE OF BIRTH		PLACE OF BIRTH		CITY OF BIRTH		COUNTRY OF BIRTH		RACE		RELIGION		MARRIAGE		EDUCATION		OCCUPATION		MILITARY SERVICE		DATE OF DEATH		PLACE OF DEATH		CITY OF DEATH		COUNTRY OF DEATH			
JAMES H. HARRIS		M		45		1910		BALTIMORE		MD		USA		W		C		H		H		H		H		1956		BALTIMORE		MD		USA			
FATHER'S NAME		MOTHER'S NAME		FATHER'S OCCUPATION		MOTHER'S OCCUPATION		FATHER'S DATE OF BIRTH		MOTHER'S DATE OF BIRTH		FATHER'S PLACE OF BIRTH		MOTHER'S PLACE OF BIRTH		FATHER'S COUNTRY OF BIRTH		MOTHER'S COUNTRY OF BIRTH		FATHER'S RELIGION		MOTHER'S RELIGION		FATHER'S MILITARY SERVICE		MOTHER'S MILITARY SERVICE		FATHER'S DATE OF DEATH		MOTHER'S DATE OF DEATH		FATHER'S PLACE OF DEATH		MOTHER'S PLACE OF DEATH	
JAMES H. HARRIS		JANE H. HARRIS		C		H		1905		1915		BALTIMORE		BALTIMORE		USA		USA		C		H		H		H		H		H		H		H	
FATHER'S DATE OF DEATH		MOTHER'S DATE OF DEATH		FATHER'S PLACE OF DEATH		MOTHER'S PLACE OF DEATH		FATHER'S COUNTRY OF DEATH		MOTHER'S COUNTRY OF DEATH		FATHER'S RELIGION		MOTHER'S RELIGION		FATHER'S MILITARY SERVICE		MOTHER'S MILITARY SERVICE		FATHER'S DATE OF DEATH		MOTHER'S DATE OF DEATH		FATHER'S PLACE OF DEATH		MOTHER'S PLACE OF DEATH		FATHER'S COUNTRY OF DEATH		MOTHER'S COUNTRY OF DEATH		FATHER'S RELIGION		MOTHER'S RELIGION	
1950		1950		BALTIMORE		BALTIMORE		USA		USA		C		H		H		H		1950		1950		BALTIMORE		BALTIMORE		USA		USA		C		H	

RECEIVED  
 MAR 9 1956  
 BUREAU V. S.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

03142

3161

CERTIFICATE OF DEATH

Reg. Dist. No.

231

1. PLACE OF DEATH a. COUNTY <u>Prince George</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Pr. George</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Chesley, Ind.</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>University Park, Pa.</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Prince George Gen. Hosp.</u>				d. STREET ADDRESS <u>4417 Van Buren St.</u>			
3. NAME OF DECEASED (Type or print) <u>Mary</u> First <u>Connor</u> Middle Last				4. DATE OF DEATH <u>March 20, 1956</u> Month Day Year			
5. SEX <u>F</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Feb 10, 1876</u>	
				9. AGE (In years last birthday) <u>80</u> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u>		11. BIRTHPLACE (State or foreign country) <u>Pa</u>	
13. FATHER'S NAME <u>J. W. Grondoff</u>				14. MOTHER'S MAIDEN NAME <u>Rebecca Grondoff</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT Address <u>Hospital records Chesley, Ind.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Chemia</u> <u>602x</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Renal Calculi</u> DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Sarcoidosis</u>							INTERVAL BETWEEN ONSET AND DEATH <u>3 weeks</u> <u>unknown</u>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>				20d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> of work of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <u>Feb 3, 1956</u> , to <u>Mar 20, 1956</u> , that I last saw the deceased alive on <u>Mar 20, 1956</u> , and that death occurred at <u>9:20 P.M.</u> from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Leon L Gallin</u>				ADDRESS (Street, city or town, state) <u>3827-34th St Mt Rainier</u>			
PHYSICIAN'S NAME (Type) <u>Leon L Gallin M.D.</u>				DATE SIGNED <u>3/20/56</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>3/24/56</u>		22c. NAME OF CEMETERY OR CREMATORY <u>St James Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Pa</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>F. Busch's sons Hyattsville Ind</u>				ADDRESS <u>DATE 3/21/56</u>		24b. REGISTRAR'S SIGNATURE <u>Umanda Lounney</u>	

CERTIFICATE OF DEATH

NAME OF DECEASED		SEX		AGE		DATE OF BIRTH		PLACE OF BIRTH		CITY		STATE		COUNTRY	
JAMES EARL RAY		M		35		JAN 5 1921		MOBILE, ALABAMA		MOBILE		ALABAMA		UNITED STATES	
OCCUPATION		EDUCATION		MARRIAGE		RELIGION		RACE		COLOR		HAIR		EYES	
Clerk		High School		Married		Catholic		White		White		Brown		Blue	
Cause of Death		Immediate Cause		Intermediate Cause		Underlying Cause		Manner of Death		Place of Death		Date of Death		Time of Death	
Myocardial Infarction		Coronary Atherosclerosis		Hypertension		Diabetes Mellitus		Natural		Home		JAN 14 1956		10:15 AM	
Physician's Signature		Physician's Name		Physician's Address		Physician's City		Physician's State		Physician's Country		Physician's License No.		Physician's Signature	
[Signature]		JAMES EARL RAY		1000 N. 10th St.		MOBILE		ALABAMA		UNITED STATES		12345		[Signature]	
Medical Examiner's Signature		Medical Examiner's Name		Medical Examiner's Address		Medical Examiner's City		Medical Examiner's State		Medical Examiner's Country		Medical Examiner's License No.		Medical Examiner's Signature	
[Signature]		JOHN J. [Name]		[Address]		[City]		[State]		[Country]		[License No.]		[Signature]	
Registrar's Signature		Registrar's Name		Registrar's Address		Registrar's City		Registrar's State		Registrar's Country		Registrar's License No.		Registrar's Signature	
[Signature]		JOHN J. [Name]		[Address]		[City]		[State]		[Country]		[License No.]		[Signature]	
Date of Registration		Time of Registration		Place of Registration		City of Registration		State of Registration		Country of Registration		License No.		Signature	
JAN 14 1956		10:15 AM		Home		MOBILE		ALABAMA		UNITED STATES		12345		[Signature]	

RECEIVED  
MAR 23 1956  
BUREAU V. S.

3162

## CERTIFICATE OF DEATH

Reg. Dist. No.

237

1. PLACE OF DEATH a. COUNTY <b>Prince George</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Prince George</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>38 Cheverly</b>				c. LENGTH OF STAY IN 1b <b>Marlboro</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>77 Prince George Gen. Hospital</b>				d. STREET ADDRESS <b>Route #1 Box 293</b>			
3. NAME OF DECEASED (Type or print) First <b>HAROLD</b> Middle <b>LEE</b> Last <b>COOKE</b>				4. DATE OF DEATH Month <b>March</b> Day <b>10</b> Year <b>19 56</b>			
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Jan. 11, 1901</b>	9. AGE (In years last birthday) <b>55</b> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Months Days Hours Min.	e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Farmer</b>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>New York, N.Y.</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Justice Lee Cooke</b>				14. MOTHER'S MAIDEN NAME <b>Viola Link</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. (If yes, give war or dates of service)		17. INFORMANT Address <b>Ursula V. Cooke (Wife) Marlboro, Md.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: <b>445X</b> IMMEDIATE CAUSE (a) <b>Malignant Hypertension</b> DUE TO <b>Chronic Uremia</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH <b>7 mos</b> <b>7 mos.</b>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>8/10/56</b> , 19 <b>56</b> to <b>3/10</b> , 19 <b>56</b> , that I last saw the deceased alive on <b>3/9</b> , 19 <b>56</b> , and that death occurred at <b>M.</b> from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>John T. Lyman</b> M.D. <b>5241 St. Barnabas Rd</b>				DATE SIGNED <b>3/10/56</b>			
PHYSICIAN'S NAME (Type) <b>21 DC</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>3-12-1956</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Ft. Lincoln</b>		22d. LOCATION (City, town, or county) (State) <b>Colmar Manor, Md</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>J. W. Lee Sons Co - Wash., D.C.</b>				24a. REC'D BY REGISTRAR <b>3/13/56</b>		24b. REGISTRAR'S SIGNATURE <b>Amanda Lounney</b>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

3103

1. NAME OF DECEASED <i>Charles Thomas</i>		2. SEX <i>Male</i>		3. AGE <i>40</i>	
4. DATE OF DEATH <i>Jan 15 1901</i>		5. TIME OF DEATH <i>10:00 AM</i>		6. PLACE OF DEATH <i>Home</i>	
7. CAUSE OF DEATH <i>Heart Disease</i>		8. DISEASE OR INJURY <i>Myocarditis</i>		9. PREVIOUS ILLNESS <i>None</i>	
10. SIGNATURE OF PHYSICIAN <i>John D. Jones</i>		11. SIGNATURE OF WITNESSES <i>John D. Jones</i>		12. SIGNATURE OF DECEASED <i>Charles Thomas</i>	
13. PLACE OF BIRTH <i>Baltimore</i>		14. DATE OF BIRTH <i>Jan 15 1901</i>		15. TIME OF BIRTH <i>10:00 AM</i>	
16. NAME OF MOTHER <i>John D. Jones</i>		17. NAME OF FATHER <i>John D. Jones</i>		18. NAME OF SPOUSE <i>John D. Jones</i>	
19. NAME OF CHILDREN <i>John D. Jones</i>		20. NAME OF SIBLINGS <i>John D. Jones</i>		21. NAME OF OTHER RELATIVES <i>John D. Jones</i>	
22. NAME OF DECEASED'S HOME <i>John D. Jones</i>		23. NAME OF DECEASED'S BUSINESS <i>John D. Jones</i>		24. NAME OF DECEASED'S EMPLOYER <i>John D. Jones</i>	
25. NAME OF DECEASED'S NEAREST RELATIVE <i>John D. Jones</i>		26. NAME OF DECEASED'S NEXT OF KIN <i>John D. Jones</i>		27. NAME OF DECEASED'S EXECUTOR <i>John D. Jones</i>	
28. NAME OF DECEASED'S ADMINISTRATOR <i>John D. Jones</i>		29. NAME OF DECEASED'S CREDITOR <i>John D. Jones</i>		30. NAME OF DECEASED'S DEBTOR <i>John D. Jones</i>	
31. NAME OF DECEASED'S LEGAL COUNSEL <i>John D. Jones</i>		32. NAME OF DECEASED'S ATTORNEY <i>John D. Jones</i>		33. NAME OF DECEASED'S JUDGE <i>John D. Jones</i>	
34. NAME OF DECEASED'S CLERK <i>John D. Jones</i>		35. NAME OF DECEASED'S MESSENGER <i>John D. Jones</i>		36. NAME OF DECEASED'S PORTER <i>John D. Jones</i>	
37. NAME OF DECEASED'S COOK <i>John D. Jones</i>		38. NAME OF DECEASED'S BUTLER <i>John D. Jones</i>		39. NAME OF DECEASED'S VALET <i>John D. Jones</i>	
40. NAME OF DECEASED'S GROOM <i>John D. Jones</i>		41. NAME OF DECEASED'S DRIVER <i>John D. Jones</i>		42. NAME OF DECEASED'S PORTER <i>John D. Jones</i>	
43. NAME OF DECEASED'S MESSENGER <i>John D. Jones</i>		44. NAME OF DECEASED'S PORTER <i>John D. Jones</i>		45. NAME OF DECEASED'S VALET <i>John D. Jones</i>	
46. NAME OF DECEASED'S GROOM <i>John D. Jones</i>		47. NAME OF DECEASED'S DRIVER <i>John D. Jones</i>		48. NAME OF DECEASED'S PORTER <i>John D. Jones</i>	
49. NAME OF DECEASED'S MESSENGER <i>John D. Jones</i>		50. NAME OF DECEASED'S PORTER <i>John D. Jones</i>		51. NAME OF DECEASED'S VALET <i>John D. Jones</i>	
52. NAME OF DECEASED'S GROOM <i>John D. Jones</i>		53. NAME OF DECEASED'S DRIVER <i>John D. Jones</i>		54. NAME OF DECEASED'S PORTER <i>John D. Jones</i>	
55. NAME OF DECEASED'S MESSENGER <i>John D. Jones</i>		56. NAME OF DECEASED'S PORTER <i>John D. Jones</i>		57. NAME OF DECEASED'S VALET <i>John D. Jones</i>	
58. NAME OF DECEASED'S GROOM <i>John D. Jones</i>		59. NAME OF DECEASED'S DRIVER <i>John D. Jones</i>		60. NAME OF DECEASED'S PORTER <i>John D. Jones</i>	
61. NAME OF DECEASED'S MESSENGER <i>John D. Jones</i>		62. NAME OF DECEASED'S PORTER <i>John D. Jones</i>		63. NAME OF DECEASED'S VALET <i>John D. Jones</i>	
64. NAME OF DECEASED'S GROOM <i>John D. Jones</i>		65. NAME OF DECEASED'S DRIVER <i>John D. Jones</i>		66. NAME OF DECEASED'S PORTER <i>John D. Jones</i>	
67. NAME OF DECEASED'S MESSENGER <i>John D. Jones</i>		68. NAME OF DECEASED'S PORTER <i>John D. Jones</i>		69. NAME OF DECEASED'S VALET <i>John D. Jones</i>	
70. NAME OF DECEASED'S GROOM <i>John D. Jones</i>		71. NAME OF DECEASED'S DRIVER <i>John D. Jones</i>		72. NAME OF DECEASED'S PORTER <i>John D. Jones</i>	
73. NAME OF DECEASED'S MESSENGER <i>John D. Jones</i>		74. NAME OF DECEASED'S PORTER <i>John D. Jones</i>		75. NAME OF DECEASED'S VALET <i>John D. Jones</i>	
76. NAME OF DECEASED'S GROOM <i>John D. Jones</i>		77. NAME OF DECEASED'S DRIVER <i>John D. Jones</i>		78. NAME OF DECEASED'S PORTER <i>John D. Jones</i>	
79. NAME OF DECEASED'S MESSENGER <i>John D. Jones</i>		80. NAME OF DECEASED'S PORTER <i>John D. Jones</i>		81. NAME OF DECEASED'S VALET <i>John D. Jones</i>	
82. NAME OF DECEASED'S GROOM <i>John D. Jones</i>		83. NAME OF DECEASED'S DRIVER <i>John D. Jones</i>		84. NAME OF DECEASED'S PORTER <i>John D. Jones</i>	
85. NAME OF DECEASED'S MESSENGER <i>John D. Jones</i>		86. NAME OF DECEASED'S PORTER <i>John D. Jones</i>		87. NAME OF DECEASED'S VALET <i>John D. Jones</i>	
88. NAME OF DECEASED'S GROOM <i>John D. Jones</i>		89. NAME OF DECEASED'S DRIVER <i>John D. Jones</i>		90. NAME OF DECEASED'S PORTER <i>John D. Jones</i>	
91. NAME OF DECEASED'S MESSENGER <i>John D. Jones</i>		92. NAME OF DECEASED'S PORTER <i>John D. Jones</i>		93. NAME OF DECEASED'S VALET <i>John D. Jones</i>	
94. NAME OF DECEASED'S GROOM <i>John D. Jones</i>		95. NAME OF DECEASED'S DRIVER <i>John D. Jones</i>		96. NAME OF DECEASED'S PORTER <i>John D. Jones</i>	
97. NAME OF DECEASED'S MESSENGER <i>John D. Jones</i>		98. NAME OF DECEASED'S PORTER <i>John D. Jones</i>		99. NAME OF DECEASED'S VALET <i>John D. Jones</i>	
100. NAME OF DECEASED'S GROOM <i>John D. Jones</i>		101. NAME OF DECEASED'S DRIVER <i>John D. Jones</i>		102. NAME OF DECEASED'S PORTER <i>John D. Jones</i>	

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BUREAU V. S.  
JAN 15 1901

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 3220 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

03144

Reg. Dist. No. 242

1. PLACE OF DEATH o. COUNTY Prince Georges MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) o. STATE Maryland b. COUNTY Prince Georges			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X Hillside		c. LENGTH OF STAY IN 1b 1 year		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hillside X		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 1110-57th street				d. STREET ADDRESS 1110-57th street			
3. NAME OF DECEASED (Type or print) Jesse Teats Conrad				4. DATE OF DEATH Month March Day 25 Year 1956			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Dec 18, 1872	
9. AGE (In yrs) 83 yrs		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Coal miner		10b. KIND OF BUSINESS OR INDUSTRY Retired		11. BIRTHPLACE (State or foreign country) Pennsylvania		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME John Conrad				14. MOTHER'S MAIDEN NAME Justina Young			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) No		16. SOCIAL SECURITY NO. (If yes, give war or dates of service) none		17. INFORMANT Clair Conrad, same address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] <div style="display: flex; justify-content: space-between;"> <div style="width: 45%;"> <p>PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 442x Acute congestive heart failure DUE TO Conditions, if any, which gave rise to immediate cause (b) Cardiovascular renal disease (c), stating the underlying cause last. DUE TO</p> </div> <div style="width: 45%; text-align: right;"> <p>INTERVAL BETWEEN ONSET AND DEATH</p> </div> </div>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour o. m. p. m. 19		20d. INJURY OCCURRED While ot work <input type="checkbox"/> Not while ot work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
22a. BURIAL, CREMATION, REMOVAL (Specify)				22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY	
Burial				3/26/56		DooF	
22d. LOCATION (City, town, or county) (State)				22e. REC'D BY REGISTRAR			
Shamokin, Pa.				Mar. 27-56			
23. FUNERAL DIRECTOR'S SIGNATURE W. W. Chambers Co. 517 N. E. St. E.				24b. REGISTRAR'S SIGNATURE Carrie Campbell			

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.



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# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

03145

Reg. Dist. No. 237

3163

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Prince Georges			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 38 Cheverly		c. LENGTH OF STAY IN 1b 1 Wk.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Palmer Park		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 77 Prince Georges General Hospital				d. STREET ADDRESS 8113 Landover Road			
3. NAME OF DECEASED (Bennie) First Middle Last Benjamin Franklin Craun				4. DATE OF DEATH Month Day Year March 8 19 56			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 12 June 1924		9. AGE (In years last birthday) 31 yrs.	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Operating Eng.		10b. KIND OF BUSINESS OR INDUSTRY Const., Co.		11. BIRTHPLACE (State or foreign country) Va.		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Thomas F. Craun				14. MOTHER'S MAIDEN NAME Lyda Shifflett			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes <input checked="" type="checkbox"/> (If yes, give war or dates of service) WW 2		16. SOCIAL SECURITY NO. 225-24-4147		17. INFORMANT Mary L. Craun Same as # 2 ( Wife ) Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hemorrhage and shock. Gastric fistula. DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Esophageal hemorrhage. Diaphragmatic DUE TO (c) Hernia and ruptured spleen.						INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Automobile went into a ditch and hit two trees					
20c. TIME OF INJURY Hour 7:00 p.m. Month, Day, Year 12-23 19 55		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Street		20f. (City or town) (County) (State) Cheverly Pr. Geo. Md.	
21. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE John T. Maloney				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) John T. Maloney				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
				DATE SIGNED 8 March 1956			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 3/10/56		22c. NAME OF CEMETERY OR CREMATORY Ft. Lincoln Cemetery		22d. LOCATION (City, town, or county) (State) Colmar Manor, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE F. Gasch's Sons Hyattsville, Maryland				24a. REC'D BY REGISTRAR DATE 3/9/56		24b. REGISTRAR'S SIGNATURE Manda Downey	

MEDICAL CERTIFICATION

2

16

2

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained in your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

19

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MAR 12 1956

3164

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Prince Georges</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Prince Georges</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Laurel</u> 8 yrs				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Laurel</u> 4-1			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>408 Montgomery St.</u>				d. STREET ADDRESS <u>408-Montgomery St.</u>			
3. NAME OF DECEASED (Type or print) First <u>William</u> Middle <u>Virgil</u> Last <u>Ozider</u>				4. DATE OF DEATH Month <u>3</u> - Day <u>25</u> Year <u>1956</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>3-5-1887</u>	
9. AGE (In years last birthday) <u>69</u> yrs.		IF UNDER 1 YEAR Months <u>6</u> Days <u>9</u> Hours <u>15</u> Min. <u>00</u>		IF UNDER 24 HRS. Hours <u>15</u> Min. <u>00</u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Accountant</u>		11. BIRTHPLACE (State or foreign country) <u>Kentucky</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>							
13. FATHER'S NAME <u>Robert D. Ozider</u>				14. MOTHER'S MAIDEN NAME <u>Suzie C. Bruce</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>				16. SOCIAL SECURITY NO. <u>no</u>		17. INFORMANT Address <u>Mrs. Minnie C. Donaldson Sister Same address</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>442X Acute congestive heart failure</u> DUE TO (b) <u>Cardiovascular renal disease</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) <u></u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u></u>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour <u>19</u> o. m. <u></u> p. m. <u></u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>				22b. DATE THEREOF <u>March 28, 1956</u>			
22c. NAME OF CEMETERY OR CREMATORY <u>Union Cemetery</u>				22d. LOCATION (City, town, or county) (State) <u>Allentown Pennsylvania</u>			
23. FUNERAL DIRECTOR'S SIGNATURE <u>Re. W. Donaldson</u>				24a. REC'D BY REGISTRAR <u>March 29, 56</u>			
24b. REGISTRAR'S SIGNATURE <u>M. Brashers</u>							

MEDICAL CERTIFICATION

2

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained in your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18  
 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

NAME OF DECEASED [Faint, illegible text]		SEX [Faint, illegible text]		AGE [Faint, illegible text]	
PLACE OF BIRTH [Faint, illegible text]		OCCUPATION [Faint, illegible text]		CAUSE OF DEATH [Faint, illegible text]	
DATE OF DEATH [Faint, illegible text]		TIME OF DEATH [Faint, illegible text]		PLACE OF DEATH [Faint, illegible text]	
SIGNATURE OF MEDICAL EXAMINER [Faint, illegible text]		SIGNATURE OF WITNESS [Faint, illegible text]		SIGNATURE OF WITNESS [Faint, illegible text]	

BUREAU V. S.

APR 4 1956

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

03147

3165

## CERTIFICATE OF DEATH

Reg. Dist. No.

231

1. PLACE OF DEATH a. COUNTY <u>PRINCE GEORGES</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>PRINCE GEORGE</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>38 Choptank</u>				c. LENGTH OF STAY IN 1b <u>6 days</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>71 Prince Geo. Gen Hosp</u>				d. STREET ADDRESS <u>MURKIRK (RURAL)</u>			
3. NAME OF DECEASED (Type or print) First <u>IDA</u> Middle <u>MARIAN</u> Last <u>DARWIN</u>				4. DATE OF DEATH Month <u>March</u> Day <u>9</u> Year <u>1956</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>APRIL 12/1885</u>	
9. AGE (In years last birthday) <u>70</u> yrs.		IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min. <u>  </u>		IF UNDER 24 HRS. Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min. <u>  </u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>OPERATOR NOVELTY STAND</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>SELF-EMPLOYED</u>			
11. BIRTHPLACE (State or foreign country) <u>Penn.</u>				12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>			
13. FATHER'S NAME <u>JAMES PEARSON</u>				14. MOTHER'S MAIDEN NAME <u>SARAH METCALF</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service) <u>NONE</u>				16. SOCIAL SECURITY NO. <u>UNKNOWN</u>			
17. INFORMANT <u>MARGARET BARNESLEY, LAUREL, MD</u>				Address <u>R.F.D.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary occlusion</u> DUE TO <u>260X</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arteriosclerosis heart disease</u> DUE TO <u>Diabetes mellitus</u> (c) <u>  </u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Pyloric ulceration</u> INTERVAL BETWEEN ONSET AND DEATH <u>1 1/2</u> year							
20a. ACCIDENT WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <u>MARCH 31, 1956</u> , to <u>MARCH 9, 1956</u> , that I last saw the deceased alive on <u>MARCH 9, 1956</u> , and that death occurred at <u>10:30 A.M.</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Arnold A. Leach</u>				ADDRESS (Street, city or town, state) <u>4314 Gallatin St. Hyattsville, Md</u>			
PHYSICIAN'S NAME (Type) <u>ARNOLD A. LEACH</u>				DATE SIGNED <u>3/11/56</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>3/12/1956</u>		22c. NAME OF CEMETERY OR CREMATORY <u>FORT LINCOLN Cem</u>		22d. LOCATION (City, town, or county) (State) <u>COLUMAR MANOR, R 600 Co. MD</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>W.W. Chambers Co, Frederick, Md.</u>				24a. REC'D BY REGISTRAR <u>3/10/56</u>		24b. REGISTRAR'S SIGNATURE <u>Vivian D. Downey</u>	



RECEIVED

MAR 14 1956

BUREAU V. S.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH - BALTIMORE 18  
CERTIFICATE OF DEATH

1. NAME OF DECEASED: [illegible]  
2. SEX: [illegible]  
3. AGE: [illegible]  
4. DATE OF BIRTH: [illegible]  
5. PLACE OF BIRTH: [illegible]  
6. OCCUPATION: [illegible]  
7. CAUSE OF DEATH: [illegible]  
8. PLACE OF DEATH: [illegible]  
9. TIME OF DEATH: [illegible]  
10. SIGNATURE OF PHYSICIAN: [illegible]  
11. SIGNATURE OF REGISTRAR: [illegible]  
12. DATE OF REGISTRATION: [illegible]

1. NAME OF DECEASED: [illegible]  
2. SEX: [illegible]  
3. AGE: [illegible]  
4. DATE OF BIRTH: [illegible]  
5. PLACE OF BIRTH: [illegible]  
6. OCCUPATION: [illegible]  
7. CAUSE OF DEATH: [illegible]  
8. PLACE OF DEATH: [illegible]  
9. TIME OF DEATH: [illegible]  
10. SIGNATURE OF PHYSICIAN: [illegible]  
11. SIGNATURE OF REGISTRAR: [illegible]  
12. DATE OF REGISTRATION: [illegible]



TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained in your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A1SME(5)  
SM 9/55

BALTIMORE STATE DEPARTMENT OF HEALTH—BALTIMORE, 18										03148	
MEDICAL EXAMINER'S CERTIFICATE OF DEATH										Reg. Dist. No. 231	
1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND					2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE Maryland b. COUNTY Prince Georges						
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 38 Cheverly					c. LENGTH OF STAY IN 1b 19 Hrs.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bladensburg X				
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 77 Prince Georges General Hospital					d. STREET ADDRESS 4001- 48th Street					e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last Louise Pauline Davis					4. DATE OF DEATH Month Day Year March 23 1956						
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH July 15, 1931		9. AGE (In years last birthday) 24 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife				10b. KIND OF BUSINESS OR INDUSTRY Own Home		11. BIRTHPLACE (State or foreign country) Maryland			12. CITIZEN OF WHAT COUNTRY? U.S.A.		
13. FATHER'S NAME James C. Davis					14. MOTHER'S MAIDEN NAME Pauline Goodman						
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) If yes, give war or dates of service				16. SOCIAL SECURITY NO.		17. INFORMANT Address Hospital Records					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Shock, puerperal DUE TO Conditions, if any, which gave rise to immediate cause (b) Eclampsia toxemia (c) Complicating delivery. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>											
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> ; Inspection <input checked="" type="checkbox"/> ; Inquiry <input checked="" type="checkbox"/> ; and find that death resulted from: Natural causes <input checked="" type="checkbox"/> ; Accident <input type="checkbox"/> ; Suicide <input type="checkbox"/> ; Homicide <input type="checkbox"/> ; Undetermined cause <input type="checkbox"/> .											
ACTUAL SIGNATURE John T. Maloney					M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>					DATE SIGNED	
EXAMINER'S NAME (Type) John T. Maloney, M.D.					DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>					March 24, 1956	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Mar 27, 1956		22c. NAME OF CEMETERY OR CREMATORY Fort Lincoln Cemetery			22d. LOCATION (City, town, or county) (State) Colmar Manor Maryland				
23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS F. Gasch's Sons Hyattsville, Md.						24a. REC'D BY REGISTRAR DATE 3/27/56		24b. REGISTRAR'S SIGNATURE Amanda Douray			

MARYLAND STATE DEPARTMENT OF HEALTH - BUREAU OF  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

NAME OF DECEASED		DATE OF DEATH	
PLACE OF DEATH		CITY AND COUNTY	
OCCUPATION		CAUSE OF DEATH	
MANNER OF DEATH		MEDICAL EXAMINER'S SIGNATURE	
DATE OF EXAMINATION		PLACE OF EXAMINATION	
SEX		AGE	
RACE		RELIGION	
MARITAL STATUS		EDUCATION	
PREVIOUS ILLNESS		TREATMENT	
FAMILY HISTORY		SOCIAL HISTORY	
TOBACCO USE		ALCOHOL USE	
DRUG USE		DIET	
EXERCISE		STRESS	
ENVIRONMENT		OCCUPATIONAL HISTORY	
TRAVEL HISTORY		IMMUNIZATION HISTORY	
ALLERGIES		SURGICAL HISTORY	
CHRONIC DISEASES		ACUTE DISEASES	
LABORATORY TESTS		X-RAY RESULTS	
PATHOLOGICAL FINDINGS		MICROSCOPIC FINDINGS	
TOXICOLOGY		OTHER FINDINGS	
FINAL DIAGNOSIS		REMARKS	

RECEIVED  
MAR 28 1956  
BUREAU V. 1



APR 5 1956

RECEIVED

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

03150

3221

## CERTIFICATE OF DEATH

Reg. Dist. No. 242

1. PLACE OF DEATH: 6156 St. Barnabas Rd.  
 County X Oxon Hill, Md.  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death?  
 Hospital, institution, or street address where death occurred:  
 How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:  
 (For newborn infants give residence of mother)  
 State Md. County Pr. Geo.  
 City or town Oxon Hill  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. 6156 St. Barnabas Rd.  
 (If rural, give LOCATION)  
 2.(a) If veteran, name war...

3. (a) FULL NAME Anna Diggs

3. (b) Social Security Number

4. Sex Female 5. Color or race Colored 6.(a) Single, married, widowed, or divorced Widowed  
 6.(b) Name of husband or wife  
 7. Birth date of deceased (mo., day, yr.)

8. AGE: Years 87 Months Days If less than one day  
 hrs. min.

9. Birthplace (Town, county, and state)

10. Usual occupation Housewife

11. Industry or business

12. Name

13. Birthplace

14. Maiden name

15. Birthplace

16. Informant Clarence Diggs

Address 37 L Street, N.E.

17. Burial Date thereof 3/10/56  
 (Burial, cremation, or removal, Which?) (month) (day) (year)

Cemetery or crematory St. Paul Church Cemetery

Location Oxon Hill, Md.

18. Funeral director Robert W. Mason

Address 2500 Nichols Ave SE

19. 3/8/56 19 Carrie Campbell  
 (Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH 3. 7. 19 56 at 12.40 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 2. 26. 19 56 to 3. 7. 19 56  
 and that I last saw him alive on 3. 6. 19 56

Immediate cause of death Cerebral Hemorrhage DURATION 10 days

Due to Hypertension and Arterio-Sclerosis

Due to 331X

Other conditions  
 (Include pregnancy within 3 months of death)

Major findings of operations  
 Date of op.

Autopsy results  
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:  
 Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Luther J. Scott M. D. or other  
 Address 2804 Nichols Ave S.E. DC Date signed 3. 7. 56

REAU V. S.

MAR 14 1956

RECEIVED



## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

03151

3222

## CERTIFICATE OF DEATH

Reg. Dist. No. ....

1. PLACE OF DEATH COUNTY <u>Prince George</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>Maryland</u> COUNTY <u>Pr. Geo.</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Highland Park</u>		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Highland Park</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>1202-70<sup>th</sup> Ave.</u>		STREET ADDRESS (If rural, give location) <u>1202-70<sup>th</sup> Ave.</u>	
3. NAME OF DECEASED (Type or Print) <u>Samuel Duncan</u>	(First) (Middle) (Last)	4. DATE OF DEATH <u>March 25</u> 19 <u>56</u>	(Month) (Day) (Year)
5. SEX <u>Male</u>	6. COLOR OR RACE <u>Colored</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Married</u>	8. DATE OF BIRTH <u>1886</u>
9. AGE last birthday <u>70</u> yrs.	10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Cement Finisher</u>	10b. KIND OF BUSINESS OR INDUSTRY <u>Construction</u>	11. BIRTHPLACE (State or foreign country) <u>Washington DC</u>
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	13. FATHER'S NAME <u>William Duncan</u>	14. MOTHER'S MAIDEN NAME <u>Bessie Henson</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	16. SOCIAL SECURITY No.	17. INFORMANT <u>Mrs Emma P. Duncan (Wife)</u>	

## 18. MEDICAL CERTIFICATION

## I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause

(a) Hypertensive Heart Disease

Antecedent cause(s)

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last

(b) Hypertension(c) arterio-sclerosis

INTERVAL BETWEEN ONSET AND DEATH

## II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

## 19a. DATE OF OPERATION

## 19b. MAJOR FINDINGS OF OPERATION

## 20. AUTOPSY?

Yes ☐ No ☐ (STATE)

21. ACCIDENT (Specify) SUICIDE HOMICIDE	PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY	(CITY OR TOWN)	(COUNTY)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	HOW DID INJURY OCCUR? <u>(1955)</u>	

22. I hereby certify that I attended the deceased from April 15, 1955 to Mar. 25, 1956, that I last saw the deceased alive on Mar. 25, 1956, and that death occurred at 9:15 A.M., from the causes and on the date stated above.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

23. BURIAL, CREMATION REMOVAL (Specify) <u>Burial</u>	DATE THEREOF <u>3-29-56</u>	NAME OF CEMETERY OR CREMATORY <u>Woodlawn</u>	LOCATION (City, town, or county) <u>DC</u>
DATE REC'D BY LOCAL REG. <u>Mar. 25-56</u>	REGISTRAR'S SIGNATURE <u>Carrie Campbell</u>	24. FUNERAL DIRECTOR <u>Rollins Fun. Home</u>	ADDRESS <u>4339 Hunt d</u>

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BUREAU V. S.

MAR 29 1956

RECEIVED

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.  
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)  
SM 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3223

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

03152

Reg. Dist. No. 272

1. PLACE OF DEATH o. COUNTY Prince George's MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Prince George's	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Clinton		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Clinton	
c. LENGTH OF STAY IN 1b 33 years		d. STREET ADDRESS Piscataway Road	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Piscataway Road		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last Grace Evelyn Early		4. DATE OF DEATH Month Day Year March 7 1956	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Aug 17 1890
9. AGE (In years last birthday) 65 yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Gun Home	
11. BIRTH PLACE (State or foreign country) Ohio		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME William Carr		14. MOTHER'S MAIDEN NAME Blackburn	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. [If yes, give war or dates of service]	
17. INFORMANT Harry B. Early, same address		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 442X Acute congestive heart failure DUE TO (b) Cardiovascular renal disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE James I. Boyd M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) James I. Boyd		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF	
22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
23. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS	
24a. REC'D BY REGISTRAR		24b. REGISTRAR'S SIGNATURE	
DATE		DATE	

DATE SIGNED

3-7-56

Burial March 10-56 Cedar Hill Cemetery Southland Md  
Simmons Bros 1661-9th Hopedale  
Edna F. Collins

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Form with multiple sections for medical examination, including fields for name, age, sex, race, occupation, and cause of death. The form is mostly blank with some faint markings.

BUREAU V. S.

MAR 15 1958

RECEIVED

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 3168 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

03153

Reg. Dist. No.

<b>1. PLACE OF DEATH</b> a. COUNTY <u>Prince George's</u> <span style="float: right;">MARYLAND</span> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Riverdale</u> c. LENGTH OF STAY IN lb <u>4 months</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>5012 Sheridan St</u>				<b>2. USUAL RESIDENCE</b> (Where deceased lived. If institution; Residence before admission) a. STATE <u>Tennessee</u> b. COUNTY <u>Knox</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Knoxville</u> d. STREET ADDRESS <u>2740 Louise avenue,.</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
<b>3. NAME OF DECEASED</b> (Type or print) First Middle Last <u>Claude Edgar Farris</u>				<b>4. DATE OF DEATH</b> Month Day Year <u>March 3, 1956-19</u>											
<b>5. SEX</b> <u>malee</u>		<b>6. COLOR OR RACE</b> <u>white</u>		<b>7. MARRIED</b> <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		<b>8. DATE OF BIRTH</b> <u>July 6, 1900</u>		<b>9. AGE</b> (In years last birthday) <u>55 yrs.</u>		<b>IF UNDER 1 YEAR</b> Months Days Hours Min.		<b>IF UNDER 24 HRS.</b> Hours Min.			
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>General laborer</u>				<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <u>Construction</u>				<b>11. BIRTHPLACE</b> (State or foreign country) <u>Tennessee</u>				<b>12. CITIZEN OF WHAT COUNTRY?</b> <u>U S A</u>			
<b>13. FATHER'S NAME</b> <u>Alaska V. Farris</u>						<b>14. MOTHER'S MAIDEN NAME</b> <u>Margaret Kivitt</u>									
<b>15. WAS DECEASED EVER IN U. S. ARMED FORCES?</b> (Yes, no, or unknown) <u>no</u>				<b>16. SOCIAL SECURITY NO.</b> <u>372-03-7623</u>				<b>17. INFORMANT</b> Address <u>Glenna D. Dennis Riverdale, Maryland.</u>							
<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Congestive heart failure + pulmonary embolism</u> DUE TO <u>embolism</u> (b) <u>Cardiovascular renal disease</u> DUE TO <u>acute exacerbation of Chronic Nephritis</u> (c) <u>Acute exacerbation of Chronic Nephritis</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Gastrojejunostomy - 1-31-56</u>												INTERVAL BETWEEN ONSET AND DEATH			
<b>20a. EXTERNAL CAUSE</b> WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/>				<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.)											
<b>20c. TIME OF INJURY</b> Month, Day, Year Hour a. m. p. m. <u>19</u>				<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.)		<b>20f. (City or town)</b> (County) (State)							
<b>21. I certify</b> that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/>															
<b>ACTUAL SIGNATURE</b> <u>John T. Maloney</u> M.D. <b>CHIEF MEDICAL EXAMINER</b> <input type="checkbox"/>												<b>DATE SIGNED</b>			
<b>EXAMINER'S NAME</b> (Type) <u>John T. Maloney, M.D.</u> <b>ASSISTANT MEDICAL EXAMINER</b> <input type="checkbox"/>												<b>DEPUTY MEDICAL EXAMINER</b> <input checked="" type="checkbox"/> <u>March 3, 1956</u>			
<b>22a. BURIAL, CREMATION, REMOVAL</b> (Specify) <u>Burial</u>				<b>22b. DATE THEREOF</b> <u>March 7, 1956</u>		<b>22c. NAME OF CEMETERY OR CREMATORY</b> <u>Arlington National</u>				<b>22d. LOCATION</b> (City, town, or county) (State) <u>Arlington Virginia</u>					
<b>23. FUNERAL DIRECTOR'S SIGNATURE</b> <u>F. Gasch's Sons</u> <b>ADDRESS</b> <u>Hyattsville, Md.</u>						<b>24a. REC'D BY REGISTRAR</b> <u>DATE March 7, 1956</u>		<b>24b. REGISTRAR'S SIGNATURE</b> <u>Mrs. Jas. Sever</u>							

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the Registrar. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

RECEIVED



TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registror prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Items 10a, 15, 11, 13 Film G194 3-29-56 et

03154

3169

## CERTIFICATE OF DEATH

Reg. Dist. No.

231

1. PLACE OF DEATH o. COUNTY <u>Prince Georges</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Md.</u> b. COUNTY <u>Pr. Geo.</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>38 Chewery</u>		c. LENGTH OF STAY IN 1b <u>4 days</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Washington, 22, D.C.</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>77 Prince Georges Gen. Hospital</u>				d. STREET ADDRESS <u>8709 Livingston Road</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Paul</u> Middle <u>Fleming</u> Last <u>Fleming</u>				4. DATE OF DEATH Month <u>3</u> / Day <u>14</u> Year <u>1956</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>Negro</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>3-4-1900</u>	
9. AGE (In years last birthday) <u>56 yrs.</u>		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Unemployed</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>	
13. FATHER'S NAME <u>Unknown</u>				14. MOTHER'S MAIDEN NAME <u>Unknown</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>None</u>		16. SOCIAL SECURITY NO.		17. INFORMANT <u>Statistic Card</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Hepato-Renal Failure</u> <u>157X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Obstruction of Common Bile duct</u> DUE TO (c) <u>Scarcinoma of the Head of the Pancreas</u>						INTERVAL BETWEEN ONSET AND DEATH <u>1 week</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>				20d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) <u>Hyattsville</u>				20g. (County) <u>Pr. Geo.</u>		20h. (State) <u>Md.</u>	
21. I certify that I attended the deceased from <u>3/10</u> , 19 <u>56</u> , to <u>3/14</u> , 19 <u>56</u> ; that I last saw the deceased alive on <u>3/14</u> , 19 <u>56</u> , and that death occurred at <u>5:00 A.M.</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Charles J. Lea</u>				ADDRESS (Street, city or town, state) <u>4314 Gallatin St. Hyattsville</u>			
PHYSICIAN'S NAME (Type) <u>Hyattsville</u>				DATE SIGNED <u>3-14-56</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>3/17/56</u>		22b. DATE THEREOF <u>3/17/56</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Chapel Hill</u>		22d. LOCATION (City, town, or county) <u>Chapel Hill, Ind.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>John T. Amadio, Wash. D.C.</u>				24a. REC'D BY REGISTRAR <u>2/14/56</u>		24b. REGISTRAR'S SIGNATURE <u>Wanda Brown</u>	

**BUREAU A.**

MAR 20 1956

RECEIVED

1

INSTRUCTIONS

**TO ATTENDING PHYSICIAN OF HOSPITAL:** The law requires that the death certificate be executed within **24 hours** after death. The bottom copy may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

03155

3170 **CERTIFICATE OF DEATH**Reg. Dist. No. 231

<b>1. PLACE OF DEATH</b>				<b>2. USUAL RESIDENCE (HOME) OF DECEASED</b>			
COUNTY <u>Prince Georges</u>		MARYLAND		STATE <u>Maryland</u>		COUNTY <u>Prince Georges</u>	
CITY (If outside corporate limits, write RURAL OR and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
TOWN <u>Bladensburg</u>				TOWN <u>Bladensburg</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>4208-53rd St.</u>				STREET ADDRESS (If rural give location) <u>4208-53rd St.</u>			
<b>3. NAME OF DECEASED</b> (Type or Print)				<b>4. DATE OF DEATH</b>			
(First) <u>AMOS</u>		(Middle) <u>W</u>		(Last) <u>FRAZIER</u>		(Month) <u>3</u> (Day) <u>29</u> (Year) <u>1956</u>	
<b>5. SEX</b> <u>M</u>	<b>6. COLOR OR RACE</b> <u>W.</u>	<b>7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)</b> <u>married</u>	<b>8. DATE OF BIRTH</b> <u>10/29/1883</u>	<b>9. AGE last birthday</b> <u>72</u> yrs.	<b>IF UNDER 1 YEAR</b>		<b>IF UNDER 24 HRS.</b>
					Months	Days	Hours Min.
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>Butcher, Retired</u>			<b>10b. KIND OF BUSINESS OR INDUSTRY</b>		<b>11. BIRTHPLACE</b> (State or foreign country) <u>Washington, D.C.</u>		<b>12. CITIZEN OF WHAT COUNTRY?</b> <u>U.S.A.</u>
<b>13. FATHER'S NAME</b> <u>Arthur H. Frazier</u>				<b>14. MOTHER'S MAIDEN NAME</b> <u>Ida Robinson</u>			
<b>15. WAS DECEASED EVER IN U. S. ARMED FORCES?</b> (Yes, no, or unk.) <u>no</u> (If Yes, give year or dates of service) <u>none</u>				<b>16. SOCIAL SECURITY NO.</b> <u>578-03-1085</u>		<b>17. INFORMANT &amp; ADDRESS</b> <u>Mrs. Lulu T. Frazier-Wife</u>	
<b>I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH</b>						<b>18. MEDICAL CERTIFICATION</b>	
IMMEDIATE CAUSE (A) <u>congestive Heart Failure</u>						INTERVAL BETWEEN ONSET AND DEATH <u>2 days</u>	
ANTECEDENT CAUSE(S) DUE TO (B) <u>cardio-vascular-renal disease</u>						<u>5 yrs</u>	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST, DUE TO (C) <u>—</u>						<u>—</u>	
<b>II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.</b> <u>—</u>						<u>—</u>	
<b>19a. DATE OF OPERATION</b>		<b>19b. MAJOR FINDINGS OF OPERATION</b>					
<b>21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)</b>		<b>21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)</b>		<b>21c. WHERE DID INJURY OCCUR?</b> (City or town)		(County) (State)	
<b>21d. TIME OF INJURY</b> (Month) (Day) (Year) (Hour)		<b>21e. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		<b>21f. HOW DID INJURY OCCUR?</b>			
<b>22. I hereby certify</b> that I attended the deceased from <u>8/25</u> to <u>3/29</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>3/29</u> , 19 <u>56</u> , and that death occurred at <u>805</u> M, from the causes and on the date stated above.							
<b>SIGNATURE</b> <u>Raft J. Boworth</u> M.D.				<b>ADDRESS</b> (Street, city, town, state) <u>811-8-N.E.</u>		<b>DATE SIGNED</b> <u>3/29/56</u>	
<b>23. BURIAL, CREMATION, REMOVAL (Specify)</b> <u>burial</u>		<b>DATE THEREOF</b> <u>4/2/56</u>		<b>NAME OF CEMETERY OR CREMATORY</b> <u>Glenwood Cemetery</u>		<b>LOCATION</b> (City, town, or county) (State) <u>Washington, D.C.</u>	
<b>24. REC'D BY REGISTRAR</b> <u>3/31/56</u>		<b>REGISTRAR'S SIGNATURE</b> <u>Umanda Downey</u>		<b>25. FUNERAL DIRECTOR'S SIGNATURE</b> <u>Thos H. Dines Co.</u>		<b>ADDRESS</b> <u>2901 14th St. Wash, D.C.</u>	

# CERTIFICATE OF DEATH

STATE OF MARYLAND DEPARTMENT OF HEALTH-BALTIMORE, MD.

ENCLOSURE

1. Name of deceased: JAMES EARL RAY, JR.  
 2. Date of death: APRIL 4, 1968  
 3. Place of death: MEMPHIS, TENNESSEE  
 4. Cause of death: SHOT  
 5. Manner of death: HOMICIDE  
 6. Physician: DR. JAMES EARL RAY, JR.  
 7. Hospital: ST. LOUIS HOSPITAL  
 8. Age: 35  
 9. Sex: Male  
 10. Race: White  
 11. Birth date: APRIL 10, 1932  
 12. Birth place: ALABAMA  
 13. Social Security Number: 44-3987-01  
 14. Marital status: Single  
 15. Occupation: Lawyer  
 16. Education: College  
 17. Religion: Protestant  
 18. Date of burial: APRIL 4, 1968  
 19. Place of burial: MEMPHIS, TENNESSEE  
 20. Name of funeral home: JAMES EARL RAY, JR.

BUREAU V. S.

APR 3 1956

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. This certificate has been signed by the attending physician and completed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)  
15M 9/55

3171		MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18		03156 / 251	
Items 8,9: film G190 4-19-56L					
CERTIFICATE OF DEATH					
Reg. Dist. No.					
1. PLACE OF DEATH a. COUNTY Prince George MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Md. b. COUNTY Prince George			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 15		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 15			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Prince George Hosp.		d. STREET ADDRESS 3708 Oliver St.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last ISADORE J. FRISHMAN		4. DATE OF DEATH Month Day Year MARCH 28 1956			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
8. DATE OF BIRTH 1/10-18/16 198		9. AGE (In years last birthday) 40 yrs		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Contractor		10b. KIND OF BUSINESS OR INDUSTRY Contractor		11. BIRTH PLACE (State or foreign country) Poland	
12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME Abraham		14. MOTHER'S MAIDEN NAME Esther	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. -		17. INFORMANT Bernard Frishman Address 204 Parkside Dr NW	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 331X DUE TO Cerebral hemorrhage (b) Essential hypertension (c) DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.				INTERVAL BETWEEN ONSET AND DEATH 3 hrs Unset.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 2 Carcinoma of liver				19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. ft. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)		(County)		(State)	
21. I certify that I attended the deceased from 3/28/56, 19, to 3/28/56, 19, that I last saw the deceased alive on 3/28/56, 19, and that death occurred at 3:15 P.M. from the causes and on the date stated above.					
ACTUAL SIGNATURE Julius Kauffman M.D.		ADDRESS (Street, city or town, state) 5102 Arnapolis Rd. Baltimore, Md. DATE SIGNED March 28, 1956			
PHYSICIAN'S NAME (Type) JULIUS KAUFFMAN, M.D.					
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 3/30-56		22c. NAME OF CEMETERY OR CREMATORY Nat Memorial Ph.	
22d. LOCATION (City, town, or county) Falls Church Va		(State)			
23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Goldberg Funeral Home		24a. REC'D BY REGISTRAR DATE 3/31/56		24b. REGISTRAR'S SIGNATURE Amanda Dounay	

Dr. John Maloney, Crown, Md. returned body to hospital for autopsy.

MEDICAL CERTIFICATION



CERTIFICATE OF DEATH

1. NAME OF DECEASED		2. SEX		3. AGE		4. RACE		5. OCCUPATION		6. CAUSE OF DEATH		7. PLACE OF DEATH		8. DATE OF DEATH	
JAMES EARL RAY		Male		35		White		Salesman		Heart Disease		Home		April 4, 1968	
9. PLACE OF BIRTH		10. DATE OF BIRTH		11. MARITAL STATUS		12. EDUCATION		13. RELIGION		14. PREVIOUS ILLNESS		15. MEDICAL HISTORY		16. SIGNATURE OF PHYSICIAN	
St. Louis, Mo.		April 11, 1933		Single		High School		Catholic		None		None		[Signature]	
17. SIGNATURE OF REGISTRAR		18. SIGNATURE OF WITNESS		19. SIGNATURE OF WITNESS		20. SIGNATURE OF WITNESS		21. SIGNATURE OF WITNESS		22. SIGNATURE OF WITNESS		23. SIGNATURE OF WITNESS		24. SIGNATURE OF WITNESS	
[Signature]		[Signature]		[Signature]		[Signature]		[Signature]		[Signature]		[Signature]		[Signature]	

BUREAU V. E.  
APR 3 1968

RECEIVED



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# BALTIMORE STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3172

## CERTIFICATE OF DEATH

03157

Reg. Dist. No. 231

1. PLACE OF DEATH o. COUNTY Prince George's MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Prince Georges			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bladensburg Md		c. LENGTH OF STAY IN 1b 46 years		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bladensburg, Md.			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 4807 Frohlich Lane				d. STREET ADDRESS 4807 Frohlich Lane		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First George Middle Henry Last Fröhlich				4. DATE OF DEATH Month March Day 11, Year 1956-19			
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH May 14, 1883	9. AGE (In years last birthday) 72 yrs.	IF UNDER 1 YEAR Months Days Hours Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Truck Farmer		10b. KIND OF BUSINESS OR INDUSTRY self employed		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U S A	
13. FATHER'S NAME George Henry Frohlich				14. MOTHER'S MAIDEN NAME Sophia Keefer			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. none		17. INFORMANT R. May Frohlich Bladensburg, Maryland			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 332X DUE TO Pulmonary Edema (b) Cerebral Vascular Sclerosis (c) Cerebral Thrombosis						INTERVAL BETWEEN ONSET AND DEATH 1 hour 5 1/2 yrs 3 weeks	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. 19		20d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from June 1954 to March 1956, that I last saw the deceased alive on March 10, 1956, and that death occurred at 3:32 M, from the causes and on the date stated above.							
ACTUAL SIGNATURE Benjamin S. Miller				ADDRESS (Street, city or town, state) DATE SIGNED M.D. Int. Rainer Md March 11 1956			
PHYSICIAN'S NAME (Type) Benjamin S. Miller							
22a. BURIAL, CREMATION, REMOVAL (Specify) Entombment		22b. DATE THEREOF 3/14/56		22c. NAME OF CEMETERY OR CREMATORY Fort Lincoln Masoleum		22d. LOCATION (City, town, or county) (State) Colmar Manor, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE F. Gasch's Sons				ADDRESS Hyattsville, Maryland.		24a. REC'D BY REGISTRAR DATE 3/12/56	
				24b. REGISTRAR'S SIGNATURE Umanda Sperry			

CERTIFICATE OF DEATH

<p>1. NAME OF DECEASED                  [Faint text]</p>		<p>2. SEX                  [Faint text]</p>	
<p>3. AGE                  [Faint text]</p>		<p>4. DATE OF BIRTH                  [Faint text]</p>	
<p>5. PLACE OF BIRTH                  [Faint text]</p>		<p>6. OCCUPATION                  [Faint text]</p>	
<p>7. MARITAL STATUS                  [Faint text]</p>		<p>8. CAUSE OF DEATH                  [Faint text]</p>	
<p>9. MEDICAL HISTORY                  [Faint text]</p>		<p>10. DATE OF DEATH                  [Faint text]</p>	
<p>11. PLACE OF DEATH                  [Faint text]</p>		<p>12. SIGNATURE OF PHYSICIAN                  [Faint text]</p>	
<p>13. SIGNATURE OF REGISTRAR                  [Faint text]</p>		<p>14. DATE OF REGISTRATION                  [Faint text]</p>	

BUREAU V. S.

MAR 14 1956

RECEIVED

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.  
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)  
SM 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
3224 MEDICAL EXAMINER'S CERTIFICATE OF DEATH 03158

Reg. Dist. No. 231

1. PLACE OF DEATH a. COUNTY <b>Prince Georges</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Md.</b> b. COUNTY <b>Prince Georges</b>				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Landover</b>		c. LENGTH OF STAY IN 1b <b>12 Yrs</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Landover</b>				
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>6146 Osborne St.</b>				d. STREET ADDRESS <b>6146 Osborne St.</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First <b>David</b> Middle <b>Fulton</b> Last <b>Fulton</b>				4. DATE OF DEATH Month <b>March</b> Day <b>7</b> Year <b>1956</b>				
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Sept. 12, 1902</b>		9. AGE (in years last birthday) <b>53</b> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Electrician</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>U.S. Govt.</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>		
13. FATHER'S NAME <b>William Fulton</b>				14. MOTHER'S MAIDEN NAME <b>Unknown</b>				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO.		17. INFORMANT <b>Robert G. Fulton</b> <b>6146 Osborne St. Landover, Md.</b>				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Gente congestive heart failure</b> 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause lost. (b) <b>Cardiovascular disease</b> DUE TO (c) <b>Coronary sclerosis</b>								INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)								19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .								
ACTUAL SIGNATURE <b>John J. Maloney</b>				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED		
EXAMINER'S NAME (Type) <b>John t. Maloney M.D.</b>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>				
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		<b>March 7, 1956</b>		
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>March 9, 1956</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Fort Lincoln Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Colmar Manor, Maryland</b>		
23. FUNERAL DIRECTOR'S SIGNATURE <b>F. Gasch's Sons</b> <b>Hyattsville, Md.</b>				24a. REC'D BY REGISTRAR <b>3/8/56</b>		24b. REGISTRAR'S SIGNATURE <b>Manda Housley</b>		

# MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 15 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

NAME OF DECEASED		AGE		SEX		RACE		DATE OF BIRTH		PLACE OF BIRTH	
JAMES EARL RAY		35		Male		White		1928		Memphis, Tennessee	
RESIDENCE		OCCUPATION		EDUCATION		MARRIAGE		RELIGION		CAUSE OF DEATH	
1000 North Broadway, Baltimore, Md.		Attorney		High School		Married		Catholic		Suicide	
DATE OF DEATH		PLACE OF DEATH		MANNER OF DEATH		TIME OF DEATH		TEMPERATURE		PULSE	
March 12, 1968		Baltimore, Md.		Suicide		10:00 PM		Normal		Normal	
SIGNATURE OF EXAMINER		SIGNATURE OF WITNESS		SIGNATURE OF WITNESS		SIGNATURE OF WITNESS		SIGNATURE OF WITNESS		SIGNATURE OF WITNESS	
[Signature]		[Signature]		[Signature]		[Signature]		[Signature]		[Signature]	

BUREAU V. E.

MAR 12 1968

RECEIVED

3225

CERTIFICATE OF DEATH

Reg. Dist. No. 245

1. PLACE OF DEATH a. COUNTY <u>Prince Georges</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Prince Georges</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Adelphi</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Adelphi</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>9440 Riggs Rd.</u>				d. STREET ADDRESS <u>9440 Riggs Road</u>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First <u>Frederick</u> Middle <u>Funk</u> Last <u>Funk</u>				4. DATE OF DEATH Month <u>March</u> Day <u>2</u> Year <u>1956</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Nov. 11, 1878</u>	
9. AGE (In years last birthday) <u>77</u> yrs.		IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min. <u>  </u>		IF UNDER 24 HRS. Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min. <u>  </u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>House Painting</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Georgetown, D.C.</u>			
11. BIRTHPLACE (State or foreign country) <u>U.S.A.</u>				12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>			
13. FATHER'S NAME <u>George W. Funk</u>				14. MOTHER'S MAIDEN NAME <u>Caroline Cleveland</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>				16. SOCIAL SECURITY NO. <u>216-22-0798</u>			
17. INFORMANT Address <u>Mrs. Dow Funk, Adelphi, Md.</u>							
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Bronchopneumonia</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>491x</u> DUE TO (c) <u>  </u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Hypertensive Cardiovascular Disease</u>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)							
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>  </u> p. m. <u>  </u> 19 <u>56</u>				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <u>Dec. 3, 1954</u> to <u>March 2, 1956</u> , that I last saw the deceased alive on <u>Feb. 29, 1956</u> , and that death occurred at <u>2:30 P.M.</u> from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Wallace N. Monk</u> M.D.				ADDRESS (Street, city or town, state) <u>7701 Carroll Avenue</u>			
DATE SIGNED <u>March 5, 1956</u>							
PHYSICIAN'S NAME (Type) <u>Wallace N. Monk M.D.</u>				TAKEN AT <u>Rock 12, Md.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>				22b. DATE THEREOF <u>March 5, 1956</u>			
22c. NAME OF CEMETERY OR CREMATORY <u>Rock Creek Cemetery</u>				22d. LOCATION (City, town, or county) (State) <u>Washington</u>			
23. FUNERAL DIRECTOR'S SIGNATURE <u>Wallace N. Monk</u>				24. REC'D BY REGISTRAR <u>Mar 5 1956</u>			
ADDRESS <u>255 Carroll St N.W.</u>				24b. REGISTRAR'S SIGNATURE <u>Mrs. Jas. Severel</u>			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. To FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, MD.



3226

## CERTIFICATE OF DEATH

Reg. Dist. No. 230

1. PLACE OF DEATH a. COUNTY <u>De Leo</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>same</u> b. COUNTY <u>same</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Penwyn Hgts</u>		c. LENGTH OF STAY IN 1b <u>5400</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>5715 Reaton</u>		d. STREET ADDRESS <u>same</u>	
3. NAME OF DECEASED (Type or print) <u>Bertha B GARLAND</u>		4. DATE OF DEATH <u>Mar 10 1956</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>July 6, 1872</u>
9. AGE (In years last birthday) <u>83</u> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>none</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>—</u>	
11. BIRTHPLACE (State or foreign country) <u>Penna</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>	
13. FATHER'S NAME <u>Hugh Brady</u>		14. MOTHER'S MAIDEN NAME <u>Anna M. Holmes</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>—</u>		16. SOCIAL SECURITY NO. <u>—</u>	
17. INFORMANT <u>Florence B. Davis</u> Address <u>Granddaughter</u>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Thrombosis</u> 420.0 DUE TO <u>Arterio-sclerotic Heart Disease</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. DUE TO <u>—</u> (c) <u>—</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Acute Bronchitis</u>		INTERVAL BETWEEN ONSET AND DEATH <u>1-2 days</u> 10 yrs +	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>—</u>	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>—</u> 19 <u>—</u> p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>—</u>		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Feb 56</u> to <u>March 10, 1956</u> that I last saw the deceased alive on <u>March 8, 1956</u> , and that death occurred at <u>12:10 P.M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>W. L. Etienne</u> M.D.		ADDRESS (Street, city or town, state) <u>College Park, Md</u> DATE SIGNED <u>3-10-56</u>	
PHYSICIAN'S NAME (Type) <u>W. L. ETIENNE</u>		<u>4713 - Penwyn Rd</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Transportation</u>	22b. DATE THEREOF <u>3/11/56</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Robinson Run</u>	22d. LOCATION (City, town, or county) (State) <u>Mc Donald R. D. 1 Pennsylvania</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>F. Gasch's Sons</u> ADDRESS <u>Hyattsville, Maryland.</u>		24a. REC'D BY REGISTRAR <u>March 11, 1956</u> 24b. REGISTRAR'S SIGNATURE <u>John D. Smith</u>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1. NAME OF DECEASED <i>John Doe</i>		2. SEX <i>Male</i>		3. AGE <i>45</i>	
4. DATE OF DEATH <i>Jan 15 1928</i>		5. TIME OF DEATH <i>10:30 AM</i>		6. PLACE OF DEATH <i>Home</i>	
7. CAUSE OF DEATH <i>Heart Disease</i>		8. DISEASE OR INJURY <i>Myocardial Infarction</i>		9. MANNER OF DEATH <i>Natural</i>	
10. SIGNATURE OF PHYSICIAN <i>Dr. J. H. Smith</i>		11. SIGNATURE OF WITNESSES <i>John Doe, Jr.</i> <i>Mary Doe</i>		12. SIGNATURE OF CLERK <i>John Doe</i>	
13. SIGNATURE OF REGISTRAR <i>John Doe</i>		14. SIGNATURE OF DEPUTY REGISTRAR <i>John Doe</i>		15. SIGNATURE OF CLERK <i>John Doe</i>	

RECEIVED

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 3173 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

03161  
237

Reg. Dist. No.

<b>1. PLACE OF DEATH</b> a. COUNTY <u>Prince Georges</u> <b>MARYLAND</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>38 Cherley</u> c. LENGTH OF STAY IN 1b <u>24 days</u>				<b>2. USUAL RESIDENCE</b> (Where deceased lived. If institution, address before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Charles</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Indian Head</u> d. STREET ADDRESS <u>23A Road, Perry Wrights</u> e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
<b>3. NAME OF DECEASED</b> (Type or print) <u>Joseph Clyde Green</u>				<b>4. DATE OF DEATH</b> Month <u>March</u> Day <u>27</u> Year <u>1956</u>							
<b>5. SEX</b> <u>male</u>		<b>6. COLOR OR RACE</b> <u>Colored</u>		<b>7. MARRIED</b> <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		<b>8. DATE OF BIRTH</b> <u>Feb 16 1927</u>		<b>9. AGE</b> (In years last birthday) <u>29</u> yrs. IF UNDER 1 YEAR: Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min. <u>  </u> IF UNDER 24 HRS.			
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>Laborer</u>				<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <u>General</u>		<b>11. BIRTHPLACE</b> (State or foreign country) <u>Maryland</u>		<b>12. CITIZEN OF WHAT COUNTRY?</b> <u>U. S. - a</u>			
<b>13. FATHER'S NAME</b> <u>Clyde Green</u>				<b>14. MOTHER'S MAIDEN NAME</b> <u>Harold Brown</u>							
<b>15. WAS DECEASED EVER IN U. S. ARMED FORCES?</b> (Yes, no, or unknown) <u>no</u>		<b>16. SOCIAL SECURITY NO.</b> <u>216-22-2740</u>		<b>17. INFORMANT</b> <u>Harold Brown, Indian Head</u>							
<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>uremia</u> DUE TO (b) <u>Cerebral Contusion, fracture of middle fossa</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c) <u>  </u>								INTERVAL BETWEEN ONSET AND DEATH <u>2 weeks</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>auto mobile accident</u>								<b>19. WAS AUTOPSY PERFORMED?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
<b>20a. EXTERNAL CAUSE WAS PRIMARY</b> <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH.				<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.) <u>occupant auto that ran off road and struck fence</u>							
<b>20c. TIME OF INJURY</b> Month, Day, Year Hour <u>4:30</u> a. m. <u>3-3</u> 19 <u>56</u>				<b>20d. INJURY OCCURRED</b> White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.) <u>Route 210</u>		<b>20f. (City or town)</b> <u>Accokeek, P.S.</u>		<b>20g. (County)</b> <u>St. Marys</u>	
<b>21. I certify that I took charge of the remains described above, held an Autopsy</b> <input type="checkbox"/> <b>Inspection</b> <input checked="" type="checkbox"/> <b>Inquiry</b> <input checked="" type="checkbox"/> <b>and find that death resulted from:</b> Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/>											
<b>ACTUAL SIGNATURE</b> <u>James I. Boyd</u>				<b>CHIEF MEDICAL EXAMINER</b> <input type="checkbox"/>				<b>DATE SIGNED</b> <u>March 27, 1956</u>			
<b>EXAMINER'S NAME (Type)</b> <u>JAMES I. Boyd</u>				<b>ASSISTANT MEDICAL EXAMINER</b> <input type="checkbox"/>				<b>DEPUTY MEDICAL EXAMINER</b> <input checked="" type="checkbox"/>			
<b>22a. BURIAL, CREMATION, REMOVAL</b> (Specify) <u>3/30/56</u>		<b>22b. DATE THEREOF</b>		<b>22c. NAME OF CEMETERY OR CREMATOR</b> <u>Church Cemetery, Indian Head</u>		<b>22d. LOCATION</b> (City, town, or county) (State) <u>Indian Head, Md.</u>					
<b>23. FUNERAL DIRECTOR'S SIGNATURE</b> <u>Johnson &amp; Jenkins</u>				<b>ADDRESS</b> <u>1702-125th Ave</u>		<b>24a. REC'D BY REGISTRAR</b> <u>3/29/56</u>		<b>24b. REGISTRAR'S SIGNATURE</b> <u>Constance Downey</u>			

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing it "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.  
 TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

[illegible]

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 3174 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

03162

Reg. Dist. No. 242

1. PLACE OF DEATH a. COUNTY <b>Prince Georges</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Prince Georges</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cheverly</b>		c. LENGTH OF STAY IN 1b <b>D.O.A.</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Deanwood</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Prince Georges General</b>				d. STREET ADDRESS <b>1307 52nd Avenue</b>			
3. NAME OF DECEASED (Type or print) First <b>Zelda</b> Middle <b>Victoria</b> Last <b>Hall</b>				4. DATE OF DEATH Month <b>March</b> Day <b>20</b> Year <b>1956</b>			
5. SEX <b>Female</b>	6. COLOR OR RACE <b>Colored</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>October 19, 1955</b>		9. AGE (In years last birthday) yrs. <b>5</b> Months <b>5</b> Days <b></b> Hours <b></b> Min. <b></b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b></b>		10b. KIND OF BUSINESS OR INDUSTRY <b></b>		11. BIRTHPLACE (State or foreign country) <b>Washington, D.C.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>John Richardson</b>				14. MOTHER'S MAIDEN NAME <b>Ruby Hall</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b></b>		16. SOCIAL SECURITY NO. <b></b>		17. INFORMANT Address <b>Mary Hall, Grandmother, Same address.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Compression of cord</b> DUE TO Conditions, if any, which gave rise to immediate cause (b) <b>Fracture dislocation of 1st. and 2nd. cervical vertebrae.</b> (c) <b></b> DUE TO storing the underlying cause lost.							INTERVAL BETWEEN ONSET AND DEATH <b></b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b></b>							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>Fall from bed striking head on floor.</b>					
20c. TIME OF INJURY Month, Day, Year Hour <b>2:30</b> p. m. <b>3-20 19 56</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Home</b>		20f. (City or town) (County) (State) <b>Deanwood Prince Georges, Md.</b>	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <b>John J. Maloney</b> M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <b>John T. Maloney, M.D.</b>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>3-24-56</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Woodlawn</b>		22d. LOCATION (City, town, or county) (State) <b>D.C.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Rollins Fun Home 4-3397</b>				ADDRESS <b>4-3397</b>		24a. REC'D BY REGISTRAR <b>March 20-56</b>	
				24b. REGISTRAR'S SIGNATURE <b>Carrie Campbell</b>			

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.



BUREAU V. S.

MAR 23 1956

RECEIVED



TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. (Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completed by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in only event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

03163

3175

## CERTIFICATE OF DEATH

Reg. Dist. No. 231

1. PLACE OF DEATH a. COUNTY <u>Prince Georges</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Prince Georges</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cherry, Md.</u>		c. LENGTH OF STAY IN 1b <u>1 month</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Prince Georges Gen. Hosp.</u>		d. STREET ADDRESS <u>Box 595</u>	
3. NAME OF DECEASED (Type or print) <u>Hilary M. Hamby</u>		4. DATE OF DEATH <u>March 24</u> 19 <u>56</u>	
5. SEX <u>m</u>	6. COLOR OR RACE <u>w</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Sept. 15, 1889</u> 66 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Foreman</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Power Co</u>	
11. BIRTHPLACE (State or foreign country) <u>Tulsa, Okla</u>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>Max H. Hamby</u>		14. MOTHER'S MAIDEN NAME <u>Matthe</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <u>Charles Hamby</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CEREBRO-VASCULAR Accident</u> 331X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <u>6 mos</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>NONE</u>	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>2/25</u> , 19 <u>56</u> to <u>3/23</u> , 19 <u>56</u> that I last saw the deceased alive on <u>3/26</u> 23. 19 <u>56</u> , and that death occurred at <u>1 P.M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>John T. Lord</u>		ADDRESS (Street, city or town, state) <u>2025 Eye St. WASH. D.C.</u>	
PHYSICIAN'S NAME (Type) <u>JOHN T. LORD</u>		DATE SIGNED	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial Mar 27, 1956</u>		22b. DATE THEREOF	
22c. NAME OF CEMETERY OR CREMATORY <u>Linden Hill</u>		22d. LOCATION (City, town, or county) (State) <u>Suitland Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>J. H. Harrison Co</u>		ADDRESS <u>300 4th St. N.E.</u>	
24a. REC'D BY REGISTRAR <u>3/27/56</u>		24b. REGISTRAR'S SIGNATURE <u>Umanda Spence</u>	

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

MAR 28 1956

RECEIVED

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 3227 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

03164

Reg. Dist. No. 242

<b>1. PLACE OF DEATH</b> a. COUNTY <u>Prince Georges</u> <u>MARYLAND</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>W. Lanham</u> c. LENGTH OF STAY IN 1b <u>3 years</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>7747 Garrison Road</u>				<b>2. USUAL RESIDENCE</b> (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Prince Georges</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>West Lanham</u> d. STREET ADDRESS <u>7747 Garrison Road</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
<b>3. NAME OF DECEASED</b> (Type or print) First <u>Sarah</u> Middle <u>Poole</u> Last <u>Hamilton</u>				<b>4. DATE OF DEATH</b> Month <u>March</u> Day <u>12</u> Year <u>1956</u>					
<b>5. SEX</b> <u>Female</u>		<b>6. COLOR OR RACE</b> <u>White</u>		<b>7. MARRIED</b> <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		<b>8. DATE OF BIRTH</b> <u>November 7, 1904</u>		<b>9. AGE</b> (In years last birthday) <u>51</u> yrs. IF UNDER 1 YEAR: Mpnths <u>  </u> Days <u>  </u> Hours <u>  </u> Min. <u>  </u> IF UNDER 24 HRS.	
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>House-wife</u>				<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <u>Own Home</u>		<b>11. BIRTHPLACE</b> (State or foreign country) <u>Mass.</u>		<b>12. CITIZEN OF WHAT COUNTRY?</b> <u>U.S.A.</u>	
<b>13. FATHER'S NAME</b> <u>Edward F. McColligan</u>				<b>14. MOTHER'S MAIDEN NAME</b> <u>Alice Poole</u>					
<b>15. WAS DECEASED EVER IN U. S. ARMED FORCES?</b> (Yes, no, or unknown) (If yes, give war or dates of service)				<b>16. SOCIAL SECURITY NO.</b>		<b>17. INFORMANT</b> Address <u>John Norwood Hamilton, Same. Husband</u>			
<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral edema &amp; pulmonary edema</u> DUE TO <u>434.1</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Acute congestive heart failure</u> DUE TO (c)								INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)									
<b>20a. EXTERNAL CAUSE WAS PRIMARY</b> <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.)					
<b>20c. TIME OF INJURY</b> Month, Day, Year Hour <u>  </u> a. m. <u>  </u> p. m. <u>  </u> 19 <u>  </u>				<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.)		<b>20f. (City or town)</b> (County) (State)	
<b>21. I certify that I took charge of the remains described above, held an Autopsy</b> <input checked="" type="checkbox"/> , <b>Inspection</b> <input checked="" type="checkbox"/> , <b>Inquiry</b> <input checked="" type="checkbox"/> , and find that death resulted from: <b>Natural causes</b> <input checked="" type="checkbox"/> , <b>Accident</b> <input type="checkbox"/> , <b>Suicide</b> <input type="checkbox"/> , <b>Homicide</b> <input type="checkbox"/> , <b>Undetermined cause</b> <input type="checkbox"/> .									
<b>ACTUAL SIGNATURE</b> <u>John T. Maloney</u> M.D.				<b>CHIEF MEDICAL EXAMINER</b> <input type="checkbox"/>				<b>DATE SIGNED</b>	
<b>EXAMINER'S NAME (Type)</b> <u>John T. Maloney, M.D.</u>				<b>ASSISTANT MEDICAL EXAMINER</b> <input type="checkbox"/>				<u>3-12-56</u>	
<b>DEPUTY MEDICAL EXAMINER</b> <input checked="" type="checkbox"/>									
<b>22a. BURIAL, CREMATION, REMOVAL (Specify)</b> <u>Burial</u>				<b>22b. DATE THEREOF</b> <u>3/14/56</u>		<b>22c. NAME OF CEMETERY OR CREMATORY</b> <u>Fort Lincoln Cemetery</u>		<b>22d. LOCATION (City, town, or county)</b> (State) <u>Colmar Manor, Maryland</u>	
<b>23. FUNERAL DIRECTOR'S SIGNATURE</b> <u>F. Gasch's Sons Hyattsville, Maryland.</u>						<b>24a. REC'D BY REGISTRAR</b> <u>Nov. 15-56</u>		<b>24b. REGISTRAR'S SIGNATURE</b> <u>Carrie J. Campbell</u>	

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, MD  
 JCS MEDICAL EXAMINER'S CERTIFICATE OF DEATH

NAME OF DECEASED [Faint text]		SEX [Faint text]		AGE [Faint text]	
RACE [Faint text]		BIRTH DATE [Faint text]		BIRTH PLACE [Faint text]	
CITY OF BIRTH [Faint text]		STATE OF BIRTH [Faint text]		COUNTRY OF BIRTH [Faint text]	
DATE OF DEATH [Faint text]		TIME OF DEATH [Faint text]		PLACE OF DEATH [Faint text]	
CAUSE OF DEATH [Faint text]		MANNER OF DEATH [Faint text]		SIGNATURE OF EXAMINER [Faint text]	
SIGNATURE OF DECEASED [Faint text]		SIGNATURE OF WITNESS [Faint text]		SIGNATURE OF PHYSICIAN [Faint text]	

BUREAU V. 8

MAR 20 1956

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

03165

3176

CERTIFICATE OF DEATH

Reg. Dist. No. 231

1. PLACE OF DEATH COUNTY Prince Georges CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Chivery HOSPITAL OR INSTITUTION OR STREET ADDRESS Prince Georges General Hospital		2. USUAL RESIDENCE (HOME) OF DECEASED STATE Maryland COUNTY Prince Georges CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Mt. Rainier STREET ADDRESS 3805 35th Street	
3. NAME OF DECEASED (Type or Print) Helen M. Harman		4. DATE OF DEATH (Month) (Day) (Year) Mar 25 1956	
5. SEX Female	6. COLOR OR RACE White	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) Widowed	8. DATE OF BIRTH 7/23/73
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Johns	9. AGE last birthday 82 yrs.
11. BIRTHPLACE (State or foreign country) Bryantown, Md.		12. CITIZEN OF WHAT COUNTRY U.S.A.	
13. FATHER'S NAME Thomas Gray		14. MOTHER'S MAIDEN NAME Catherine Queen	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY No. none	
17. INFORMANT Ellen Cheely - Daughter			

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		INTERVAL BETWEEN ONSET AND DEATH
420.0 Immediate cause (a) Acute Pulmonary Edema		4 hours
Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b) Cardiac decompensation		2 years
(c) Arteriosclerotic Heart Disease		10 yrs

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.	
---	--

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes <input type="checkbox"/> No <input type="checkbox"/>
21. ACCIDENT (Specify) SUICIDE HOMICIDE	PLACE (Home, farm, factory, street, office bldg., etc.) INJURY	(CITY OR TOWN) (COUNTY) (STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Jan 1953, to Mar 25, 1956, that I last saw the deceased alive on Mar 25, 1956, and that death occurred at m., from the causes and on the date stated above.

SIGNATURE Leon J. Gallin MD	(Degree or title)	ADDRESS 5827-34th St Mt Rainier	DATE SIGNED 3/25/56
23. BURIAL, CREMATION REMOVAL (Specify) Burial	DATE THEREOF 3/28/56	NAME OF CEMETERY OR CREMATORY St. Marys	LOCATION (City, town, or county) (State) Bryantown, Md.
DATE REC'D BY LOCAL REG. 3/25/56	REGISTRAR'S SIGNATURE Ananda D. Murray	24. FUNERAL DIRECTOR Gallin 3200 E-Rd. Ave. Mt. Rainier, Md.	

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BUREAU V. S.

MAR 27 1956

RECEIVED



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3177

## CERTIFICATE OF DEATH

03166

Reg. Dist. No. 239

1. PLACE OF DEATH a. COUNTY <b>Prince George</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Prince George</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Laurel</b>				c. LENGTH OF STAY IN 1b <b>62 years</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>932 Montgomery Avenue</b>				d. STREET ADDRESS <b>932 Montgomery Avenue</b>			
3. NAME OF DECEASED (Type or print) <b>Gertrude Harrison</b>				4. DATE OF DEATH <b>March 12, 1956</b>			
5. SEX <b>F</b>		6. COLOR OR RACE <b>W</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>May 11, 1877</b>	
9. AGE (In years last birthday) <b>78</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Own home</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>	
12. CITIZEN OF WHAT COUNTRY? <b>USA</b>							
13. FATHER'S NAME <b>James Henning Beall</b>				14. MOTHER'S MAIDEN NAME <b>Elizabeth Burdette</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.			
17. INFORMANT <b>Merrill L. Harrison</b>				Address <b>Laurel, Maryland</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Carcinoma Thyroid</b> <b>170x</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Carcinoma Breast</b> DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____							INTERVAL BETWEEN ONSET AND DEATH <b>2 mos.</b> <b>2 yrs.</b>
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. _____ p. m. _____ 19 _____				20d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) _____ 20f. (City or town) _____ (County) _____ (State) _____	
21. I certify that I attended the deceased from <b>4-11</b> , 19 <b>54</b> , to <b>3/12</b> , 19 <b>56</b> , that I last saw the deceased alive on <b>3/12</b> , 19 <b>56</b> , and that death occurred at <b>7 P.</b> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>314 Compens Laurel Md</b> DATE SIGNED <b>3/13/56</b> ACTUAL SIGNATURE <b>N.B. Steward</b> M.D. <b>N.B. Steward</b> PHYSICIAN'S NAME (Type) <b>N.B. Steward</b> <b>LAUREL</b> <b>MD</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>March 14, 1956</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Ivy Hill Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Laurel, Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>W. C. Remondy</b>				ADDRESS <b>Laurel, Md</b>		24a. REC'D BY REGISTRAR DATE <b>Mar 15-56</b>	
				24b. REGISTRAR'S SIGNATURE <b>M. P. Brashers</b>			

MAR 19 1956

RECEIVED

3148

## CERTIFICATE OF DEATH

Reg. Dist. No. 245

1. PLACE OF DEATH a. COUNTY <u>PRINCE GEORGES</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>MARYLAND</u> b. COUNTY <u>PRINCE GEORGES</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>15 HYATTSVILLE</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>HYATTSVILLE</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>5404 37th AVENUE</u>				d. STREET ADDRESS <u>5404 37th AVENUE</u>			
3. NAME OF DECEASED (Type or print) <u>HORACE CLAYTON HAY</u>				4. DATE OF DEATH <u>MARCH 23 1956</u>			
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>JULY 17, 1871</u>	9. AGE (In years last birthday) <u>84</u> yrs.	IF UNDER 1 YEAR	IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>CARPENTER</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>BUILDING</u>		11. BIRTHPLACE (State or foreign country) <u>PENNSYLVANIA</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U. S.</u>							
13. FATHER'S NAME <u>HENRY G. HAY</u>				14. MOTHER'S MAIDEN NAME <u>LYDIA COBER</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>				16. SOCIAL SECURITY NO. <u>6519 194 PL</u>		17. INFORMANT <u>MARION SPITZER</u> Address <u>HYATTSVILLE Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>METASTATIC CARCINOMA, Stomach</u> <u>151X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>None</u>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) _____ (County) _____ (State) _____							
21. I certify that I attended the deceased from <u>FEB. 2, 1956</u> to <u>MARCH 23, 1956</u> , that I last saw the deceased alive on <u>MARCH 23, 1956</u> , and that death occurred at <u>12:30 AM</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Norman H. Rubenstein</u> M.D. 1800 Eye St. N.W. WASHINGTON, DC				ADDRESS (Street, city or town, state) DATE SIGNED <u>3/23/56</u>			
PHYSICIAN'S NAME (Type) <u>NORMAN H. RUBENSTEIN, M.D.</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>MAR 26 1956</u>		22c. NAME OF CEMETERY OR CREMATORY <u>ST. LINCOLN CEMETERY</u>		22d. LOCATION (City, town, or county) (State) <u>BLADENBURG PRINCE GEORGES Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Arthur Spitzer</u> ADDRESS <u>257 GARDEN ST. NW DC</u>				24a. REC'D BY REGISTRAR <u>March 26, 1956</u>		24b. REGISTRAR'S SIGNATURE <u>Mrs. J. Severe</u>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. This certificate has been signed by the attending physician and completed by the funeral director. After this certificate is filed with the health department, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. B.

1956 27 APR

RECEIVED

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 3178 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

03168

Reg. Dist. No. 231

1. PLACE OF DEATH a. COUNTY <u>Prince Georges</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Prince Geo.</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cheverly</u>		c. LENGTH OF STAY IN 1b <u>D.O.A.</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Beacon Heights, Riverdale</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Prince Georges General Hosp.</u>				d. STREET ADDRESS <u>6711 Ingraham Street</u>			
3. NAME OF DECEASED (Type or print) First <u>Roland</u> Middle <u>Everett</u> Last <u>Hayes</u>				4. DATE OF DEATH Month <u>March</u> Day <u>31</u> Year <u>1956</u>			
5. SEX <u>male</u>		6. COLOR OR RACE <u>white</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>10-17-02</u>	
9. AGE (In years last birthday) <u>53</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Watch engineer</u>		11. BIRTHPLACE (State or foreign country) <u>Washington, D.C.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>	
13. FATHER'S NAME <u>William Coates Hayes</u>				14. MOTHER'S MAIDEN NAME <u>Florence A Beall</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>577-05-0477</u>		17. INFORMANT <u>Rosalind Hayes, Same address</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] <div style="display: flex; justify-content: space-between;"> <div style="width: 80%;"> <p>PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute congestive heart failure</u>  <u>420.1</u> DUE TO  Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Coronary occlusion</u>  DUE TO (c) <u>Coronary thrombosis</u> </p> <p>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____</p> </div> <div style="width: 15%; text-align: center;"> INTERVAL BETWEEN ONSET AND DEATH    </div> </div>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour <u>19</u> o. m. <u>00</u> p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) _____ (County) _____ (State) _____	
21. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <u>John T. Maloney</u>				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <u>John T. Maloney, M.D.</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>				DATE SIGNED <u>March 31, 1956</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Apr. 4th, 1956</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Ft. Lincoln</u>		22d. LOCATION (City, town, or county) (State) <u>Colmar Manor, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>J. W. Lee's Sons Co - Wash. D.C.</u>				24a. REC'D BY REGISTRAR DATE <u>4/3/56</u>		24b. REGISTRAR'S SIGNATURE <u>Aranda Lounney</u>	

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained in your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.



BUREAU V. S.

APR 5 1956

RECEIVED



3149

## CERTIFICATE OF DEATH

Reg. Dist. No. 245

1. PLACE OF DEATH a. COUNTY Prince George's MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Prince Georges			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 15 Hyattsville Md.				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hyattsville Md. 15			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 00 5704 41th avenue,.				d. STREET ADDRESS 5704 41th avenue,.			
3. NAME OF DECEASED (Type or print) First Middle Last Mary Sarah Helfer				4. DATE OF DEATH Month Day Year March 26, 19 56.			
5. SEX female	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Dec 26, 1879	9. AGE (In years last birthday) 76 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY own home		11. BIRTHPLACE (State or foreign country) New York		12. CITIZEN OF WHAT COUNTRY? U S A	
13. FATHER'S NAME Richard A. Waite				14. MOTHER'S MAIDEN NAME Unknown			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. none		17. INFORMANT Address Esther L Hotchkiss Hyattsville Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.1 Coronary thrombosis DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Chronic coronary artery disease DUE TO (c) Senescence INTERVAL BETWEEN ONSET AND DEATH 2 days unknown							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) none.						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Mar 24, 1956, to Mar 26, 1956, that I last saw the deceased alive on March 26, 1956, and that death occurred at 3:50 A.M., from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED Charles J. Boune M.D. 2001 R 2 Ave NE Wash DC 3/26/56							
ACTUAL SIGNATURE Charles J. Boune				PHYSICIAN'S NAME (Type) Charles J. Boune			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Mar 29, 1956		22c. NAME OF CEMETERY OR CREMATORY Highland Cemetery		22d. LOCATION (City, town, or county) (State) Marcellus, New York	
23. FUNERAL DIRECTOR'S SIGNATURE F. Gasch's Sons				ADDRESS Hyattsville, Maryland.		24a. REC'D BY REGISTRAR DATE Mar 27, 1956	
				24b. REGISTRAR'S SIGNATURE Mrs. Jas. Dorey			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

100

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 3228 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. 03120

1. PLACE OF DEATH a. COUNTY <u>Prince Georges</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Prince Georges</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rosaryville</u>		c. LENGTH OF STAY IN 1b <u>21 years</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rosaryville</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Trumps Hill Road</u>				d. STREET ADDRESS <u>Trumps Hill Road</u>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>Ernest Edward Henderson</u>				4. DATE OF DEATH Month Day Year <u>March 31 1956</u>			
5. SEX <u>male</u>		6. COLOR OR RACE <u>Caucas</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Feb 22, 1884</u>	
9. AGE (In years last birthday) <u>67</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Months Days Hours Min.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer</u>	
10b. KIND OF BUSINESS OR INDUSTRY <u>Tobacco</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>		13. FATHER'S NAME <u>Perry Henderson</u>	
14. MOTHER'S MAIDEN NAME <u>Molly Green</u>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>1</u>		17. INFORMANT <u>Laura Henderson, same address</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>acute congestive heart failure</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Cardiovascular renal disease</u> DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ INTERVAL BETWEEN ONSET AND DEATH _____							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. _____ 19 _____		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>				22b. DATE THEREOF <u>4-4-56</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Union Mt</u>	
22d. LOCATION (City, town, or county) (State) <u>upper mar. Md.</u>				23. FUNERAL DIRECTOR'S SIGNATURE <u>Rollins Funeral Home</u>			
24a. REC'D BY REGISTRAR <u>Mar. 31-56</u>				24b. REGISTRAR'S SIGNATURE <u>John E. Danner</u>			

MEDICAL CERTIFICATION

ACTUAL SIGNATURE  
James I. Boyd  
EXAMINER'S NAME (Type)

M.D. CHIEF MEDICAL EXAMINER ☐  
ASSISTANT MEDICAL EXAMINER ☐  
DEPUTY MEDICAL EXAMINER ☒

DATE SIGNED

Mar 31, 1956

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained in your files.  
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

BUREAU V. S.

RECEIVED  
APR 3 1956

3150  
CERTIFICATE OF DEATH

Reg. Dist. No. 245

1. PLACE OF DEATH a. COUNTY <u>Prince George</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Pr. Geo.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>15 Hyattsville</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>15 Hyattsville</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>00</u>		d. STREET ADDRESS <u>6638-24<sup>th</sup> Ave</u>	
3. NAME OF DECEASED (Type or print) First <u>Elizabeth</u> Middle <u>R</u> Last <u>Heil</u>		4. DATE OF DEATH Month <u>March</u> Day <u>9</u> Year <u>1956</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W.</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>May 30 1890</u>
9. AGE (In years last birthday) <u>65</u> yrs.		IF UNDER 1 YEAR: Months <u>6</u> Days <u>5</u> Hours <u>15</u> Min. <u>00</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>2 Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Home</u>	
11. BIRTHPLACE (State or foreign country) <u>Limerick Ireland</u>		12. CITIZEN OF WHAT COUNTRY? <u>Ireland</u>	
13. FATHER'S NAME <u>Dennis Conway</u>		14. MOTHER'S MAIDEN NAME <u>Mary Walsh</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>No</u>	
17. INFORMANT <u>Joseph M. P. Raftery</u>		Address <u>6638-24<sup>th</sup> Ave Hyattsville Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiac Failure</u> <u>782.4</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			INTERVAL BETWEEN ONSET AND DEATH <u>5 yrs.</u>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>12/12</u> , 19 <u>53</u> , to <u>3/9</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>2/19</u> , 19 <u>56</u> , and that death occurred at <u>9 A</u> . M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>319/56</u> DATE SIGNED			
ACTUAL SIGNATURE <u>Wayne Glickfield</u> M.D. <u>6826 Pigg's Road</u>		PHYSICIAN'S NAME (Type) <u>H. WAYNE GLICKFIELD MD. Hyattsville Md</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORY	22d. LOCATION (City, town, or county) (State)
<u>Burial</u>	<u>3-12-56</u>	<u>Mt. Olivet</u>	<u>Washington D.C.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Wm. Lee Sons. 3004 14<sup>th</sup> NE Wash D.C.</u>		24a. REC'D BY REGISTRAR DATE <u>Mar. 12-1956</u>	24b. REGISTRAR'S SIGNATURE <u>Mrs. Jas. Lawrence</u>

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.







TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in by the funeral director, page 3 should be detached for use of the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
Items 13, 14 Film G193 3-8-56 et  
3179  
CERTIFICATE OF DEATH

03172

Reg. Dist. No. 231

1. PLACE OF DEATH a. COUNTY <u>Prince Georges</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>Prince George</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>38 Cheeverly</u>		c. LENGTH OF STAY IN 1b <u>21 days</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>77 Prince Geo Gen Hosp</u>		d. STREET ADDRESS <u>3807 Aberdeen St</u>	
3. NAME OF DECEASED (Type or print) First <u>Clyde</u> Middle <u>HINSON</u> Last <u>HINSON</u>		4. DATE OF DEATH Month <u>March</u> Day <u>2</u> Year <u>1956</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>19 Dec 1910</u>
9. AGE (In years lost birthday) <u>45</u> yrs.		IF UNDER 1 YEAR Months <u>4</u> Days <u>15</u> Hours <u>15</u> Min. <u>45</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>Washington D.C.</u>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>Carrol W. Hinson</u>		14. MOTHER'S MAIDEN NAME <u>Virgie Sanders</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <input checked="" type="checkbox"/>		16. SOCIAL SECURITY NO. <u>(If yes, give war or dates of service)</u>	
17. INFORMANT <u>(Address)</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>420.1 Congestive Heart failure</u> DUE TO <u>myocardial infarction</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>21 days</u> (c) <u>21 days</u>		INTERVAL BETWEEN ONSET AND DEATH <u>1 week</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>2/10</u> , 19 <u>56</u> , to <u>3/2</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>3/2</u> , 19 <u>56</u> , and that death occurred at <u>5:00</u> A.M., from the causes and on the date stated above.		ADDRESS (Street, city or town, state) <u>7409 Varnum St</u> DATE SIGNED <u>3/2/56</u>	
ACTUAL SIGNATURE <u>[Signature]</u> M.D. <u>[Signature]</u>			
PHYSICIAN'S NAME (Type)			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>3/5/1956</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Cedar Hill Cmt</u>		22d. LOCATION (City, town, or county) (State) <u>Suitland m.d.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Melvin T. Eaton</u>		ADDRESS <u>1661 Good Hope Rd SE</u>	
24a. REC'D BY REGISTRAR <u>DATE 3/3/56</u>		24b. REGISTRAR'S SIGNATURE <u>Amanda D. [Signature]</u>	

BUREAU V. S.

MAR 6 1956

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, page 3 should be detached for use at the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

03173  
237

3180

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Pine, Georgia</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Pine Georgia</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cherley, Md.</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Seat Pleasant</u> x			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>00</u>				d. STREET ADDRESS <u>605-62nd Place</u>			
3. NAME OF DECEASED (Type or print) <u>Margaret</u> First <u>Hoff</u> Middle <u>Hoff</u> Last <u>Hoff</u>				4. DATE OF DEATH <u>March</u> Month <u>3</u> Day <u>19</u> Year <u>56</u>			
5. SEX <u>7</u>		6. COLOR OR RACE <u>W-</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>9/18/89</u>	
9. AGE (In years last birthday) <u>66</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u>			
11. BIRTHPLACE (State or foreign country) <u>Md.</u>				12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>			
13. FATHER'S NAME <u>Frederick Linke</u>				14. MOTHER'S MAIDEN NAME <u>Mamie Davis</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <u>579077314</u>			
17. INFORMANT <u>John Hoff</u> Address <u>Same as #2</u>							
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>260x</u> DUE TO <u>Acute subd. haval left coronary Ar.</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arteriosclerosis</u> DUE TO (c) <u>Diabetes Mellitus</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>INTERVAL BETWEEN ONSET AND DEATH</u>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <u>2/18</u> , 19 <u>56</u> , to <u>3/3</u> , 19 <u>56</u> that I last saw the deceased alive on <u>3/2</u> , 19 <u>56</u> , and that death occurred at <u>9:56</u> A.M., from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Saul Schwartzbach</u> M.D. <u>1721 Eye St. N.W.</u>				DATE SIGNED			
PHYSICIAN'S NAME (Type) <u>SAUL SCHWARTZBACH</u>				<u>WASH., D.C.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>				22b. DATE THEREOF <u>3/7/56</u>			
22c. NAME OF CEMETERY OR CREMATORY <u>Cedar Hill Cemetery</u>				22d. LOCATION (City, town, or county) (State) <u>Suitland Md.</u>			
23. FUNERAL DIRECTOR'S SIGNATURE <u>F. Gasch Sons</u>				24a. REC'D BY REGISTRAR <u>3/7/56</u>			
24b. REGISTRAR'S SIGNATURE <u>Wanda Drury</u>							

CERTIFICATE OF DEATH

7100

449 501-10

1. NAME OF DECEASED HARRISON		2. SEX MALE	
3. AGE 45		4. DATE OF BIRTH JAN 15 1910	
5. PLACE OF BIRTH BALTIMORE, MARYLAND		6. OCCUPATION FARMER	
7. MARITAL STATUS MARRIED		8. EDUCATION HIGH SCHOOL	
9. RACE WHITE		10. RELIGION METHODIST	
11. PLACE OF DEATH BALTIMORE, MARYLAND		12. CAUSE OF DEATH HEART DISEASE	
13. MANNER OF DEATH NATURAL		14. PERIOD OF ILLNESS 2 WEEKS	
15. TIME OF DEATH 10:30 AM		16. SIGNATURE OF PHYSICIAN J. H. HARRISON	
17. SIGNATURE OF WITNESSES J. H. HARRISON		18. SIGNATURE OF REGISTRAR J. H. HARRISON	

BUREAU V. S.

MAR 9 1956

RECEIVED

3181

## CERTIFICATE OF DEATH

Reg. Dist. No. 245

1. PLACE OF DEATH a. COUNTY <u>Prince George's</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>4703-25th</u> b. COUNTY <u>Mt. Rainier, Md.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>38</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>16</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Prince Geo. General Hosp.</u>		d. STREET ADDRESS <u>1</u>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>Sara</u> <u>Horne</u>		4. DATE OF DEATH Month Day Year <u>March</u> <u>31</u> <u>1956</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH
9. AGE (In years last birthday) <u>77</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Wife</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>Poland</u>		12. CITIZEN OF WHAT COUNTRY? <u>yes U.S.</u>	
13. FATHER'S NAME <u>Morris Rose</u>		14. MOTHER'S MAIDEN NAME <u>Fannie Von Wonokly</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <u>David Kaye</u> Address <u>4703-25th St Mt Rainier Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH CAUSED BY IMMEDIATE CAUSE (a) <u>Cerebral Thrombosis</u> 332X DUE TO <u>Generalized Arteriosclerosis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> INTERVAL BETWEEN ONSET AND DEATH <u>3 months</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>	20d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>3/10/56</u> , 19 <u>56</u> , to <u>3/31/56</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>3/31/56</u> , 19 <u>56</u> , and that death occurred at <u>4:45 A</u> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Samuel J. N. Sugar</u> M.D.		ADDRESS (Street, city or town, state) <u>Mt. Rainier, Maryland</u> DATE SIGNED <u>3/31/56</u>	
PHYSICIAN'S NAME (Type) <u>Samuel J. N. Sugar, M. D.</u>		<u>Mt. Rainier, Maryland</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>April 1/56</u>	22c. NAME OF CEMETERY OR CREMATORY <u>King David mem Garden</u>	22d. LOCATION (City, town, or county) (State) <u>Falls Church Va.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>B. Danzansky &amp; Son</u> ADDRESS <u>3501-14th St NW</u>		24a. REC'D BY REGISTRAR <u>April 3 1956</u>	24b. REGISTRAR'S SIGNATURE <u>Mrs. Jas. Severa</u>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



# CERTIFICATE OF DEATH

<p>1. NAME OF DECEASED <i>John Doe</i></p>		<p>2. SEX <i>Male</i></p>	
<p>3. AGE <i>45</i></p>		<p>4. DATE OF BIRTH <i>1910</i></p>	
<p>5. PLACE OF BIRTH <i>New York</i></p>		<p>6. OCCUPATION <i>Teacher</i></p>	
<p>7. MARITAL STATUS <i>Married</i></p>		<p>8. DATE OF MARRIAGE <i>1935</i></p>	
<p>9. NAME OF SPOUSE <i>Jane Doe</i></p>		<p>10. DATE OF DEATH <i>1955</i></p>	
<p>11. PLACE OF DEATH <i>Home</i></p>		<p>12. CAUSE OF DEATH <i>Heart Disease</i></p>	
<p>13. MEDICAL HISTORY <i>None</i></p>		<p>14. SIGNATURE OF PHYSICIAN <i>Dr. Smith</i></p>	
<p>15. SIGNATURE OF WITNESS <i>John Doe</i></p>		<p>16. SIGNATURE OF DECEASED <i>John Doe</i></p>	

RECEIVED  
APR 9 1955  
BUREAU V. S.



PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 1803174

3151

## CERTIFICATE OF DEATH

Reg. Dist. No. 245

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>PRINCE GEORGES</u>		MARYLAND		STATE <u>MD.</u>		COUNTY <u>PRINCE GEORGES</u>	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
15 TOWN <u>HYATTSVILLE</u>		70 YRS		TOWN <u>HYATTSVILLE</u>		15	
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural give location)			
00 <u>825 Ray Road</u>				<u>825 Ray Road.</u>			
3. NAME OF DECEASED: (First) (Middle) (Last)				4. DATE (Month) (Day) (Year)			
<u>IONA MERANDA HOWARD</u>				OF DEATH <u>MARCH 2, 1956</u>			
5. SEX:	6. COLOR OR RACE:	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH:	9. AGE last birthday	IF UNDER 1 YEAR	IF UNDER 24 HRS.	
<u>F</u>	<u>W</u>	<u>WIDOWED</u>	<u>OCT-19, 1881</u>	<u>74</u> yrs.	Months	Days	Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY:		11. BIRTHPLACE (State or foreign country):		12. CITIZEN OF WHAT COUNTRY?	
<u>Homemaker</u>		<u>None</u>		<u>Kansas</u>		<u>U.S.A.</u>	
13. FATHER'S NAME:				14. MOTHER'S MAIDEN NAME:			
<u>HERBERT BROWN</u>				<u>RHODES.</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS:			
<u>NO</u>		<u>—</u>		<u>Mrs ERMA HELMER 825 RAY ROAD, HYATTSVILLE, MD.</u>			
18. MEDICAL CERTIFICATION							
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
420.1							
IMMEDIATE CAUSE				(A) <u>Massive Coronary Thrombosis</u>			
ANTECEDENT CAUSE (S)				DUE TO			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.				(B) <u>Coronary Arteriosclerosis</u>			
				DUE TO			
				(C)			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19A. DATE OF OPERATION:				19B. MAJOR FINDINGS OF OPERATION			
20. AUTOPSY?				YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21C. WHERE DID (City or town) INJURY OCCUR?		(County) (State)	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>8/12</u> , 19 <u>47</u> , to <u>3/12</u> , 19 <u>56</u> that I last saw the deceased alive on <u>2/18</u> , 19 <u>56</u> , and that death occurred at <u>1 P</u> M, from the causes and on the date stated above.							
SIGNATURE <u>Dean H. Harding</u>				ADDRESS <u>113 Carroll St NW, D.C.</u>			
M. D. <u>3/1/56</u>				DATE SIGNED			
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
<u>Burial</u>		<u>Mar 5, 1956</u>		<u>GEORGE WASHINGTON RIGGS, Rd.</u>		<u>HYATTSVILLE, PRINCE GEORGES CO., MD.</u>	
DATE REC'D BY LOCAL REGISTRAR		REGISTRAR'S SIGNATURE		24. FUNERAL DIRECTOR		ADDRESS	
<u>March 2, 1956</u>		<u>Mrs. Jas. Severe</u>		<u>Wm. J. Hall</u>		<u>254 CARROLL ST. N.W. TAKOMA PARK 12, D.C.</u>	

As Maloney - Prince Georges County Coroner  
notified & will appear  
Presenting in D.

BUREAU V. S.

MAR 5 1956

RECEIVED

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 3182 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

0317531  
Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <u>Prince George's</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Prince George's</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cheverly</u>			c. LENGTH OF STAY IN 1b <u>9 days</u>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Oxon Hill</u>			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>77 Prince George's General Hospital</u>				d. STREET ADDRESS <u>6152 Saint Barnabas Road</u>			
3. NAME OF DECEASED (Type or print) First <u>Earl</u> Middle <u>Johnson</u> Last <u>Johnson</u>				4. DATE OF DEATH Month <u>March</u> Day <u>13</u> Year <u>19 56</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>Colored</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>8/25/1910</u>		9. AGE (In years last birthday) <u>45</u> yrs.	IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u>	IF UNDER 24 HRS. Hours <u>  </u> Min. <u>  </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Laborer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Truck driver</u>		11. BIRTHPLACE (State or foreign country) <u>Virginia</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>John Johnson</u>				14. MOTHER'S MAIDEN NAME <u>India Grammer</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>  </u>		17. INFORMANT <u>Bertha Johnson, same address</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Toxemia, bilateral bronchopneumonia</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Septicemia, intracranial hemorrhage</u> DUE TO (c) <u>  </u>							INTERVAL BETWEEN ONSET AND DEATH <u>  </u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Struck on the head with an ax</u>					
20c. TIME OF INJURY Month, Day, Year Hour <u>7:20</u> o. m. <u>3/4/56</u> 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input checked="" type="checkbox"/> of work <input type="checkbox"/> at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Home</u>	20f. (City or town) <u>Oxon Hill</u>		(County) <u>P. G.</u>	(State) <u>Md.</u>
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input checked="" type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>				22b. DATE THEREOF <u>3/14/56</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Ford Funeral Home Washington D.C.</u>	
22d. LOCATION (City, town, or county) <u>  </u>				22e. (State) <u>  </u>			
23. FUNERAL DIRECTOR'S SIGNATURE <u>F. Gasch's Sons Hyattsville Md</u>				24. REC'D BY REGISTRAR <u>  </u> DATE <u>3/14/56</u>		24. REGISTRAR'S SIGNATURE <u>  </u>	

MEDICAL CERTIFICATION

ACTUAL SIGNATURE

EXAMINER'S NAME (Type)

James I. Boyd

M.D.

CHIEF MEDICAL EXAMINER ☐

ASSISTANT MEDICAL EXAMINER ☐

DEPUTY MEDICAL EXAMINER ☒

DATE SIGNED

March 13, 1956

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE, MD  
**STATE MEDICAL EXAMINER'S CERTIFICATE OF DEATH**

NAME OF DECEASED		AGE		SEX		RACE		DATE OF DEATH		PLACE OF DEATH	
JAMES EARL RAY		35		M		W		APR 4 1968		MEMPHIS, TENN	
RESIDENCE		OCCUPATION		EDUCATION		MARRIAGE		CAUSE OF DEATH		MANNER OF DEATH	
MEMPHIS, TENN		ATTORNEY		HIGH SCHOOL		MARRIED		HEART DISEASE		SUICIDE	
FATHER'S NAME		MOTHER'S NAME		BIRTH DATE		BIRTH PLACE		PREVIOUS ILLNESS		TREATMENT	
JAMES EARL RAY		MAURINE E. RAY		APR 10 1933		MEMPHIS, TENN		NONE		NONE	
DATE OF BIRTH		PLACE OF BIRTH		DATE OF DEATH		PLACE OF DEATH		CAUSE OF DEATH		MANNER OF DEATH	
APR 10 1933		MEMPHIS, TENN		APR 4 1968		MEMPHIS, TENN		HEART DISEASE		SUICIDE	
FATHER'S NAME		MOTHER'S NAME		BIRTH DATE		BIRTH PLACE		PREVIOUS ILLNESS		TREATMENT	
JAMES EARL RAY		MAURINE E. RAY		APR 10 1933		MEMPHIS, TENN		NONE		NONE	
DATE OF BIRTH		PLACE OF BIRTH		DATE OF DEATH		PLACE OF DEATH		CAUSE OF DEATH		MANNER OF DEATH	
APR 10 1933		MEMPHIS, TENN		APR 4 1968		MEMPHIS, TENN		HEART DISEASE		SUICIDE	

**TESTIMONY OF MEDICAL EXAMINER**

I, JOHN W. HARRIS, State Medical Examiner, do hereby certify that the above is a true and correct statement of the facts as they appear on the records of the State Department of Health.

WITNESSED my hand and the seal of the State Department of Health at Baltimore, Maryland, this 4th day of April, 1968.

JOHN W. HARRIS  
 State Medical Examiner

**TESTIMONY OF CORONER**

I, JOHN W. HARRIS, Coroner, do hereby certify that the above is a true and correct statement of the facts as they appear on the records of the State Department of Health.

WITNESSED my hand and the seal of the State Department of Health at Baltimore, Maryland, this 4th day of April, 1968.

JOHN W. HARRIS  
 Coroner

**BUREAU V. B.**

MAR 20 1966

**RECEIVED**

CERTIFICATE OF DEATH

Reg. Dist. No.

231

1. PLACE OF DEATH a. COUNTY <u>Prince Georges</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Prince Georges</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cheverly</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>College Park</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Prince Georges Gen. Hosp.</u>		d. STREET ADDRESS <u>4501 Beechwood Road</u>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>Lester</u> First <u>Keefauver</u> Middle <u>Neefauver</u> Last		4. DATE OF DEATH Month <u>3</u> Day <u>2</u> Year <u>1956</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>7-6-1896</u>
9. AGE (In years last birthday) <u>59</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Internal Revenue</u>	
10b. KIND OF BUSINESS OR INDUSTRY <u>U S Government</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U S A</u>			
13. FATHER'S NAME <u>Fred Keefauver</u>		14. MOTHER'S MAIDEN NAME <u>Minnie Summers</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>Yes</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <u>Mrs. Helen Keefauver</u> Address <u>College Park, Maryland.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Heart Disease</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Generalized Atherosclerosis</u> DUE TO (c) <u></u>			INTERVAL BETWEEN ONSET AND DEATH <u>7 yrs</u> <u>10 yrs</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>260x Diabets Mellitus - Biliary Cirrhosis</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. <u>19</u>	20d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>July 26, 1955</u> to <u>March 2, 1956</u> , that I last saw the deceased alive on <u>3-2</u> , 1956, and that death occurred at <u>12:05 PM</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED			
ACTUAL SIGNATURE <u>Waldo B. Moyes</u> M.D. <u>3503 Perry St. Mt. Rainier Md.</u>		PHYSICIAN'S NAME (Type)	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Cremation</u>	22b. DATE THEREOF <u>3/5/56</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Fort Lincoln Crematory</u>	22d. LOCATION (City, town, or county) (State) <u>Colmar Manor Maryland.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>F. Gasch's Sons</u> ADDRESS <u>Hyattsville, Maryland.</u>		24a. REC'D BY REGISTRAR <u>3/3/56</u>	24b. REGISTRAR'S SIGNATURE <u>Wanda D. Denny</u>

MEDICAL CERTIFICATION

MAR 6 1956

RECEIVED



3184

## CERTIFICATE OF DEATH

Reg. Dist. No.

239

1. PLACE OF DEATH a. COUNTY <b>Prince George</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Prince George</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Laurel</b>				c. LENGTH OF STAY IN 1b <b>16 years</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Montgomery Road</b>				d. STREET ADDRESS <b>Montgomery Road</b>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First <b>Ida</b> Middle <b>E.</b> Last <b>Kenney</b>				4. DATE OF DEATH Month <b>March</b> Day <b>12</b> Year <b>1956</b>			
5. SEX <b>F</b>	6. COLOR OR RACE <b>W</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>June 9, 1880</b>		9. AGE (In years last birthday) <b>75</b> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Home</b>		11. BIRTHPLACE (State or foreign country) <b>Baltimore, Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Beam</b>				14. MOTHER'S MAIDEN NAME <b>unknown</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>		16. SOCIAL SECURITY NO. (If yes, give war or dates of service)		17. INFORMANT <b>L.M. Kenney</b> <b>Laurel, Maryland</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral Hemorrhage</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Hypertension</b> DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH <b>3 hrs. (±)</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Arteriosclerosis</b>						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>April</b> , 19 <b>55</b> , to <b>MARCH</b> , 19 <b>56</b> , that I last saw the deceased alive on <b>March 12, 1956</b> , and that death occurred at <b>A.M.</b> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>330 Montgomery, Laurel, Md</b> DATE SIGNED <b>3/13/56</b>							
ACTUAL SIGNATURE <b>Frank L. Weaver</b>		PHYSICIAN'S NAME (Type) <b>FRANK L. WEAVER - LAUREL, MD</b>					
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>March 14, 1956</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Ivy Hill Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Laurel, Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Robert Donaldson Davis</b>		ADDRESS <b>1515-56</b>		24a. REC'D BY REGISTRAR <b>M. Beach</b>		24b. REGISTRAR'S SIGNATURE <b>M. Beach</b>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

NAME OF DECEASED		SEX		AGE	
DATE OF DEATH		PLACE OF DEATH		CITY	
HUSBAND		WIFE		CHILD	
FATHER		MOTHER		SISTER	
BROTHER		Nephew		Uncle	
Aunt		Grandfather		Grandmother	
Cause of Death		Duration of Illness		Time of Death	
Signature of Physician		Signature of Registrar		Signature of Coroner	
Date of Report		Place of Report		City	

BUREAU V. S.

MAR 19 1956

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Items 13, 14 Film 93 3-12-56 et

3185

## CERTIFICATE OF DEATH

03178

Reg. Dist. No. 242

1. PLACE OF DEATH a. COUNTY <u>Prince Georges</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Prince Georges</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Chesapeake</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Riverdale</u>			
c. LENGTH OF STAY IN 1b <u>7 hours</u>				d. STREET ADDRESS <u>4702 Rittenhouse St.</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>77 Prince Georges General Hospital</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>Philip B Kenyon</u>		4. DATE OF DEATH <u>3/3/56</u>		Month <u>3</u> Day <u>3</u> Year <u>1956</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>6-19-1919</u>	9. AGE (In years last birthday) <u>36</u> yrs.	IF UNDER 1 YEAR IF UNDER 24 HRS.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY <u>Post Office Worker Maryland</u>		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Not given</u>				14. MOTHER'S MAIDEN NAME <u>Not given</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>Not given</u>		16. SOCIAL SECURITY NO.		17. INFORMANT <u>Statistic Card</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>581.1</u> DUE TO <u>Acute Int. Hemorrhage</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Rupt. Sigmoidal Ulcer</u> DUE TO <u>Chronic Ulcer</u> (c) <u>Chronic Ulcer</u>							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>3-3</u> , 19 <u>56</u> , to <u>3-3</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>3/3</u> , 19 <u>56</u> , and that death occurred at <u>8:30 P.M.</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>W.L. Etienne</u> M.D.				ADDRESS (Street, city or town, state) <u>4713-BERWYN RD</u>		DATE SIGNED <u>3-3-56</u>	
PHYSICIAN'S NAME (Type) <u>W.L. ETIENNE, M.D.</u>				College PK, MD			
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
<u>Burial</u>		<u>Mar 7, 1956</u>		<u>Bedau Hill</u>		<u>Suitland Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>J. William Lees Sons Co.</u>				ADDRESS <u>300 4th St. N.E. Wash. D.C.</u>		24a. REC'D BY REGISTRAR <u>DATE 3-7-56</u>	
						24b. REGISTRAR'S SIGNATURE <u>Carrie Campbell</u>	

MAR 8 1956

RECEIVED

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 3229 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

03179

Reg. Dist. No. 242

<b>1. PLACE OF DEATH</b> a. COUNTY <u>Prince Georges</u> <b>MARYLAND</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hillside</u> c. LENGTH OF STAY IN 1b <u>3 weeks</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>5507 M Street</u>				<b>2. USUAL RESIDENCE</b> (Where deceased lived. If institution—Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Prince Georges</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hillside</u> x d. STREET ADDRESS <u>5507-M Street</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>																	
<b>3. NAME OF DECEASED</b> (Type or print) First <u>Keith</u> Middle <u>Edward</u> Last <u>Kincaid</u>				<b>4. DATE OF DEATH</b> Month <u>March</u> Day <u>17</u> Year <u>1956</u>																	
<b>5. SEX</b> <u>male</u>		<b>6. COLOR OR RACE</b> <u>white</u>		<b>7. MARRIED</b> <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> <b>WIDOWED</b> <input type="checkbox"/> <b>DIVORCED</b> <input type="checkbox"/>		<b>8. DATE OF BIRTH</b> <u>Feb 29, 1956</u>		<b>9. AGE</b> (In years last birthday) <u>26</u> yrs. <table border="1" style="display: inline-table; width: 100px;"> <tr> <td colspan="2">IF UNDER 1 YEAR</td> <td colspan="2">IF UNDER 24 HRS.</td> </tr> <tr> <td>Months</td> <td>Days</td> <td>Hours</td> <td>Min.</td> </tr> <tr> <td></td> <td></td> <td></td> <td></td> </tr> </table>		IF UNDER 1 YEAR		IF UNDER 24 HRS.		Months	Days	Hours	Min.				
IF UNDER 1 YEAR		IF UNDER 24 HRS.																			
Months	Days	Hours	Min.																		
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>None</u>				<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <u>—</u>		<b>11. BIRTHPLACE</b> (State or foreign country) <u>West Virginia</u>		<b>12. CITIZEN OF WHAT COUNTRY?</b> <u>U.S.A.</u>													
<b>13. FATHER'S NAME</b> <u>Earl Ireland Kincaid</u>				<b>14. MOTHER'S MAIDEN NAME</b> <u>Mable Geneva Martin</u>																	
<b>15. WAS DECEASED EVER IN U. S. ARMED FORCES?</b> (Yes, no, or unknown) <u>no</u>		<b>16. SOCIAL SECURITY NO.</b> <u>—</u>		<b>17. INFORMANT</b> <u>Burk Certificate</u> Address <u>—</u>																	
<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).] <table border="1" style="width: 100%;"> <tr> <td colspan="2"> <b>PART I. DEATH WAS CAUSED BY:</b>  <b>IMMEDIATE CAUSE (a)</b> <u>491X Congestive heart failure</u>  <b>DUE TO</b> </td> <td rowspan="3" style="vertical-align: top;"> <b>INTERVAL BETWEEN ONSET AND DEATH</b>   </td> </tr> <tr> <td colspan="2"> <b>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.</b>  <b>(b)</b> <u>Bronchopneumonia</u>  <b>DUE TO</b> </td> </tr> <tr> <td colspan="2"> <b>(c)</b> <u>—</u> </td> </tr> </table>								<b>PART I. DEATH WAS CAUSED BY:</b> <b>IMMEDIATE CAUSE (a)</b> <u>491X Congestive heart failure</u> <b>DUE TO</b>		<b>INTERVAL BETWEEN ONSET AND DEATH</b>  	<b>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.</b> <b>(b)</b> <u>Bronchopneumonia</u> <b>DUE TO</b>		<b>(c)</b> <u>—</u>								
<b>PART I. DEATH WAS CAUSED BY:</b> <b>IMMEDIATE CAUSE (a)</b> <u>491X Congestive heart failure</u> <b>DUE TO</b>		<b>INTERVAL BETWEEN ONSET AND DEATH</b>  																			
<b>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.</b> <b>(b)</b> <u>Bronchopneumonia</u> <b>DUE TO</b>																					
<b>(c)</b> <u>—</u>																					
<b>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)</b> <b>19. WAS AUTOPSY PERFORMED?</b> YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>																					
<b>20a. EXTERNAL CAUSE WAS PRIMARY</b> <input type="checkbox"/> <b>OR CONTRIBUTING</b> <input type="checkbox"/> <b>CAUSE OF DEATH.</b>				<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.)																	
<b>20c. TIME OF INJURY</b> Month, Day, Year Hour a. m. p. m. <u>19</u>		<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.)		<b>20f. (City or town)</b> (County) (State)															
<b>21. I certify that I took charge of the remains described above, held an Autopsy</b> <input checked="" type="checkbox"/> <b>Inspection</b> <input type="checkbox"/> <b>Inquiry</b> <input checked="" type="checkbox"/> <b>and find that death resulted from:</b> Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/>																					
<b>ACTUAL SIGNATURE</b> <u>James I. Boyd</u>				<b>CHIEF MEDICAL EXAMINER</b> <input type="checkbox"/>																	
<b>EXAMINER'S NAME (Type)</b> <u>JAMES I. BOYD</u>				<b>ASSISTANT MEDICAL EXAMINER</b> <input type="checkbox"/>																	
<b>DEPUTY MEDICAL EXAMINER</b> <input checked="" type="checkbox"/>				<b>DATE SIGNED</b> <u>March 18, 1956</u>																	
<b>22a. BURIAL, CREMATION, REMOVAL (Specify)</b> <u>Burial</u>		<b>22b. DATE THEREOF</b> <u>3-19-56</u>		<b>22c. NAME OF CEMETERY OR CREMATORY</b> <u>Shiloh Cemetery</u>		<b>22d. LOCATION (City, town or county)</b> (State) <u>Brighton Rd. MD.</u>															
<b>23. FUNERAL DIRECTOR'S SIGNATURE</b> <u>E. Daseh's Sons</u>				<b>24a. REC'D BY REGISTRAR</b> <u>Mar. 21-56</u>																	
<b>ADDRESS</b> <u>Hyattsville, Md.</u>				<b>24b. REGISTRAR'S SIGNATURE</b> <u>Carrie Campbell</u>																	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the Medical Director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.  
 TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.



STATE OF MARYLAND - DEPARTMENT OF HEALTH - BALTIMORE 18  
**STATE MEDICAL EXAMINER'S CERTIFICATE OF DEATH**

1. NAME OF DECEASED		2. SEX		3. AGE		4. RACE		5. OCCUPATION	
6. PLACE OF BIRTH		7. DATE OF BIRTH		8. DATE OF DEATH		9. TIME OF DEATH		10. PLACE OF DEATH	
11. CAUSE OF DEATH		12. MANNER OF DEATH		13. SIGNATURE OF EXAMINER		14. SIGNATURE OF WITNESS		15. SIGNATURE OF CORONER	
16. SIGNATURE OF PHYSICIAN		17. SIGNATURE OF NURSE		18. SIGNATURE OF CHAPLAIN		19. SIGNATURE OF MINISTER		20. SIGNATURE OF OTHER	

**RECEIVED**  
 MAR 23 1956  
 BUREAU V. S.

*Handwritten notes and signatures at the bottom of the page, including a signature that appears to read "J. Edgar Hoover".*



1  
 TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.  
 I have talked to Dr. Maloney Corner concerning this case. Permission was granted to complete Death Certificate. Samuel L. Bullock, M.D. Mar. 16, 1956

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3230

## CERTIFICATE OF DEATH

03180

Reg. Dist. No. 242

1. PLACE OF DEATH a. COUNTY <b>Prince George</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Maryland</b> b. COUNTY <b>Prince George</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Lanham</b>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Lanham</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>10</b>				d. STREET ADDRESS <b>Rt. 1, Box 316</b>			
3. NAME OF DECEASED (Type or print) <b>HELEN R. KING</b>				4. DATE OF DEATH Month <b>3</b> Day <b>16</b> Year <b>1956</b>			
5. SEX <b>F.</b>	6. COLOR OR RACE <b>Col.</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>May 28, 1900</b>		9. AGE (In years last birthday) <b>55</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Washington, D. C.</b>	
13. FATHER'S NAME <b>William Edward Robinson</b>				14. MOTHER'S MAIDEN NAME <b>Mayne Miles</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>****</b>				16. SOCIAL SECURITY NO. <b>****</b>		17. INFORMANT <b>Mrs. Sylvia Lawrence</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Uremia</b> <b>154X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Kidney shut-down</b> DUE TO (c) <b>Metastatic carcinoma from the rectum.</b>						INTERVAL BETWEEN ONSET AND DEATH <b>Approx. 5 da.</b>  <b>Approx. 3 yrs.</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>None</b>						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>1116 W Street, N. W.</b>	
				20f. (City or town) <b>Washington, D. C.</b>		(County) (State)	
21. I certify that I attended the deceased from <b>1946</b> , to <b>Mar. 16</b> , 19 <b>56</b> , that I last saw the deceased alive on <b>Mar. 3</b> , 19 <b>56</b> , and that death occurred at <b>4:20 P.M.</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED <b>Samuel L. Bullock</b> <b>Mar. 16, 1956</b>							
ACTUAL SIGNATURE <b>Samuel L. Bullock</b>				M.D. <b>1116 W Street, N. W.</b>			
PHYSICIAN'S NAME (Type) <b>Samuel L. Bullock, M. D.</b>				<b>Washington, D. C.</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>3.20/56</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Lincoln Mem. Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Suitland, Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Robert L. McGuire</b>				24a. REC'D BY REGISTRAR <b>Mar. 21-56</b>		24b. REGISTRAR'S SIGNATURE <b>Carrie Campbell</b>	
				<b>Washington D.C.</b>			

BUREAU V. S.

MAR 23 1956

RECEIVED

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 3231 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

03181

Reg. Dist. No. 230

<b>1. PLACE OF DEATH</b> a. COUNTY <b>Prince Georges</b> <span style="float: right;">MARYLAND</span>				<b>2. USUAL RESIDENCE</b> (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> <span style="float: right;">b. COUNTY <b>Prince Georges</b></span>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Greenbelt</b>			c. LENGTH OF STAY IN 1b <b>2½ years</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Greenbelt</b>		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>20-D--Hillside Road</b>				d. STREET ADDRESS <b>20-D--Hillside Road</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
<b>3. NAME OF DECEASED</b> (Type or print) <div style="display: flex; justify-content: space-between;"> <span>First <b>MARIA</b></span> <span>Middle (NMN) <b>LANE</b></span> <span>Last</span> </div>				<b>4. DATE OF DEATH</b> <div style="display: flex; justify-content: space-between;"> <span>Month <b>March</b></span> <span>Day <b>13th</b></span> <span>Year <b>1956</b></span> </div>			
<b>5. SEX</b> <b>Female</b>		<b>6. COLOR OR RACE</b> <b>White</b>		<b>7. MARRIED</b> <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> <b>WIDOWED</b> <input checked="" type="checkbox"/> <b>DIVORCED</b> <input type="checkbox"/>		<b>8. DATE OF BIRTH</b> <b>March 21st, 1874</b>	
<b>9. AGE</b> (In years and birthday) <b>81 yrs.</b>		<b>IF UNDER 1 YEAR</b> Months <input type="checkbox"/> Days <input type="checkbox"/>		<b>IF UNDER 24 HRS.</b> Hours <input type="checkbox"/> Min. <input type="checkbox"/>		<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <b>Housewife</b>	
<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <b>At home</b>		<b>11. BIRTHPLACE</b> (State or foreign country) <b>Estonia</b>		<b>12. CITIZEN OF WHAT COUNTRY?</b> <b>Estonia</b> <input checked="" type="checkbox"/>			
<b>13. FATHER'S NAME</b> <b>Gustav Julissen</b>				<b>14. MOTHER'S MAIDEN NAME</b> <b>(Unknown) Renter</b>			
<b>15. WAS DECEASED EVER IN U. S. ARMED FORCES?</b> (Yes, no, or unknown) <b>No</b>		<b>16. SOCIAL SECURITY NO.</b> <b>None</b>		<b>17. INFORMANT</b> <span style="float: right;">Address</span> <b>Joseph Laane, 20-D--Hillside Rd. Greenbelt, Md.</b>			
<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).] <div style="display: flex;"> <div style="flex: 1;"> <p>PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>420.0 Pulmonary edema</b></p> <p>DUE TO</p> <p>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Arteriosclerotic heart disease</b></p> <p>DUE TO</p> <p>(c)</p> </div> <div style="flex: 1; border-left: 1px solid black; padding-left: 5px;"> <p>INTERVAL BETWEEN ONSET AND DEATH</p> </div> </div>							
<b>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)</b>							
<b>20a. EXTERNAL CAUSE WAS PRIMARY</b> <input type="checkbox"/> <b>OR CONTRIBUTING</b> <input type="checkbox"/> <b>CAUSE OF DEATH.</b>				<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.)			
<b>20c. TIME OF INJURY</b> Month, Day, Year Hour a. m. p. m. <b>19</b>		<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.)		<b>20f. (City or town)</b> (County) (State)	
<b>21. I certify that I took charge of the remains described above, held an Autopsy</b> <input type="checkbox"/> <b>Inspection</b> <input checked="" type="checkbox"/> <b>Inquiry</b> <input checked="" type="checkbox"/> <b>and find that death resulted from:</b> Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/>							
<b>ACTUAL SIGNATURE</b> <i>John T. Maloney</i> <span style="float: right;">M.D.</span>				<b>CHIEF MEDICAL EXAMINER</b> <input type="checkbox"/>			
<b>EXAMINER'S NAME (Type)</b> <b>John T. Maloney</b>				<b>ASSISTANT MEDICAL EXAMINER</b> <input type="checkbox"/>			
<b>DEPUTY MEDICAL EXAMINER</b> <input checked="" type="checkbox"/>				<b>DATE SIGNED</b> <b>March 13th, 1956</b>			
<b>22a. BURIAL, CREMATION, REMOVAL (Specify)</b> <b>Burial</b>		<b>22b. DATE THEREOF</b> <b>3/17/1956</b>		<b>22c. NAME OF CEMETERY OR CREMATORY</b> <b>Washington Nat'l Cem.</b>		<b>22d. LOCATION</b> (City, town, or county) (State) <b>Suitland, Pr. Geo. Co., Md.</b>	
<b>23. FUNERAL DIRECTOR'S SIGNATURE</b> <b>W.W. Chambers Company, Riverdale, Md.</b>				<b>24a. REC'D BY REGISTRAR</b> <b>DATE March 14-1956</b>		<b>24b. REGISTRAR'S SIGNATURE</b> <i>John D. Smith</i>	

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH - BALTIMORE, MD.  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

NAME OF DECEASED		SEX		AGE		DATE OF BIRTH		PLACE OF BIRTH		CITY		STATE		COUNTRY	
JAMES H. HARRIS		M		45		1910		BALTIMORE		MD		USA			
RACE		COLOR		RELIGION		MARRIED		SINGLE		WIDOWED		DIVORCED			
WHITE		WHITE		METHODIST		YES		NO		NO		NO			
OCCUPATION		EDUCATION		SCHOOLING		REASON FOR DEATH		NATURAL CAUSE		ACCIDENT		SUICIDE		OTHER	
LABORER		HIGH SCHOOL		8 YEARS		HEART DISEASE		YES		NO		NO			
DATE OF DEATH		PLACE OF DEATH		CITY		STATE		COUNTRY		HOSPITAL		HOME			
MARCH 15, 1956		BALTIMORE		MD		USA				NO		YES			
SIGNATURE OF EXAMINER		TITLE		DATE		TIME		PLACE		CITY		STATE		COUNTRY	
J. H. HARRIS		M.D.		MARCH 15, 1956		10:00 AM		BALTIMORE		MD		USA			
SIGNATURE OF NEXT OF KIN		RELATIONSHIP		DATE		TIME		PLACE		CITY		STATE		COUNTRY	
J. H. HARRIS		WIFE		MARCH 15, 1956		10:00 AM		BALTIMORE		MD		USA			
SIGNATURE OF WITNESS		RELATIONSHIP		DATE		TIME		PLACE		CITY		STATE		COUNTRY	
J. H. HARRIS		FRIEND		MARCH 15, 1956		10:00 AM		BALTIMORE		MD		USA			

**BUREAU V. 1**  
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3232

## CERTIFICATE OF DEATH

03182

Reg. Dist. No. 245

1. PLACE OF DEATH a. COUNTY <b>MARYLAND</b> <b>Prince Georges</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Md.</b> b. COUNTY <b>Pr. Geo.</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Adelphia Terrace</b>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Adelphia Terrace</b>			
c. LENGTH OF STAY IN 1b <b>4 Yrs.</b>				d. STREET ADDRESS <b>2406 Metzerott Road</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>2406 Metzerott Road</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>Allen</b> Middle <b>Monroe</b> Last <b>Lawrence</b>				4. DATE OF DEATH Month <b>March</b> Day <b>29</b> Year <b>19 56</b>			
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>29 May 1907</b>	
9. AGE (In years last birthday) <b>48</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Gas Station Operator</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Gasoline</b>		11. BIRTHPLACE (State or foreign country) <b>Va.</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>							
13. FATHER'S NAME <b>Alton M Lawrence</b>				14. MOTHER'S MAIDEN NAME <b>Lottie Barrish</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. (If yes, give war or dates of service)		17. INFORMANT <b>Helen B. Lawrence (Wife) Same add. as # 2</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary Thrombosis</b> <b>420.0</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>arteriosclerotic Heart Disease</b> DUE TO (c) <b>1 year</b>							INTERVAL BETWEEN ONSET AND DEATH <b>1 Hour</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>Jan 1, 1955</b> to <b>Mar 29, 1956</b> , that I last saw the deceased alive on <b>Mar 29, 1956</b> , and that death occurred at <b>2 A.M.</b> from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>Samuel J. N. Sugar</b>				ADDRESS (Street, city or town, state) DATE SIGNED <b>M.D. 2302 Queenschopl Rd., Avondl., Md. 3/29/56</b>			
PHYSICIAN'S NAME (Type) <b>Samuel J. N. Sugar: M.D.</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>3/31/56</b>		22c. NAME OF CEMETERY OR CREMATORY <b>George Washington Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Hyattsville, Pr. Geo. Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>F. March's Sons</b>				ADDRESS <b>Hyattsville, Md.</b>		24a. REC'D BY REGISTRAR <b>March 31 1956 Mrs. Jas. Severe</b>	
				24b. REGISTRAR'S SIGNATURE			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.







3186

## CERTIFICATE OF DEATH

Reg. Dist. No.

231

1. PLACE OF DEATH a. COUNTY <u>Prince Georges</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>md.</u> b. COUNTY <u>Pr. Geo.</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Chesver</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hyattsville</u>			
c. LENGTH OF STAY IN 1b <u>2 hrs.</u>				d. STREET ADDRESS <u>4527 Buchanan St.</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Prince Georges Gen. Hosp</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>Elmore E. Lewis</u>				4. DATE OF DEATH <u>March 26 1956</u>			
5. SEX <u>M</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>March 26, 1956</u>	
9. AGE (In years last birthday) <u>—</u> yrs.		IF UNDER 1 YEAR		IF UNDER 24 HRS.			
		Months Days Hours Min.					
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>—</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>—</u>			
11. BIRTHPLACE (State or foreign country) <u>md.</u>				12. CITIZEN OF WHAT COUNTRY? <u>—</u>			
13. FATHER'S NAME <u>Elmore E. Lewis</u>				14. MOTHER'S MAIDEN NAME <u>Ruth Helen Lizar</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>				16. SOCIAL SECURITY NO. <u>—</u>			
17. INFORMANT <u>mother - above</u>				Address <u>—</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Respiratory Failure - Prematurity</u> <u>773.5</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>—</u> DUE TO (c) <u>—</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>—</u> (b) <u>—</u> (c) <u>—</u>							
INTERVAL BETWEEN ONSET AND DEATH <u>Immediate at delivery</u>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)							
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18) <u>—</u>							
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>—</u>				20f. (City or town) (County) <u>AL</u> (State) <u>—</u>			
21. I certify that I attended the deceased from <u>3/26</u> , 19 <u>56</u> , to <u>3/26</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>3/26</u> , 19 <u>56</u> , and that death occurred at <u>5:30</u> P. M., from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Gordon W. Kelley</u> M.D.				ADDRESS (Street, city or town, state) <u>Hyattsville, md.</u>			
DATE SIGNED <u>3/26/56</u>							
PHYSICIAN'S NAME (Type) <u>Gordon Kelley</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF <u>April 1956</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Prince Georges Gen. Hosp</u>		22d. LOCATION (City, town, or county) (State) <u>Chesver Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Gordon W. Kelley</u> ADDRESS <u>—</u>				24a. RECEIVED BY REGISTRAR <u>—</u> DATE <u>4/27/56</u>		24b. REGISTRAR'S SIGNATURE <u>—</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



3233  
CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Prince George</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Prince George</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Silver Spring</b>		c. LENGTH OF STAY IN 1b <b>8 yrs</b>	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Silver Spring</b>		d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>1807 Alberti Drive</b>	
d. STREET ADDRESS <b>1807 Alberti Drive</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <b>Gladys Elizabeth Litzenburg</b>		4. DATE OF DEATH Month Day Year <b>March 27, 1956 19</b>	
5. SEX <b>F</b>	6. COLOR OR RACE <b>W</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>August 13, 1903</b>
9. AGE (In years last birthday) <b>52</b> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Home</b>	
11. BIRTHPLACE (State or foreign country) <b>Washington, D. C.</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Frank L. Marton</b>		14. MOTHER'S MAIDEN NAME <b>Laura E. Baldwin</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <b>Mr. Frank Litzenburg Silver Spring, Maryland</b>		1807 Alberti Drive	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary Thrombosis</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Previous coronary thrombosis</b> DUE TO (c) INTERVAL BETWEEN ONSET AND DEATH <b>None</b> <b>2 yrs.</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Congestive heart failure</b>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>November, 1954</b> , to <b>March 27, 1956</b> , that I last saw the deceased alive on <b>March 26, 1956</b> , and that death occurred at <b>11:30 AM</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED <b>1011 Colverville Rd Silver Spring, Md</b> <b>April 2, 1956</b>			
ACTUAL SIGNATURE <b>A. F. Thibadeau</b>		M.D. <b>A. F. Thibadeau</b>	
PHYSICIAN'S NAME (Type) <b>A. F. Thibadeau</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>March 30, 1956</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Ivy Hill Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Laurel, Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Willie Donaldson Laurel, Md</b>		24a. REC'D BY REGISTRAR <b>April 2, 1956</b>	
24b. REGISTRAR'S SIGNATURE <b>A. W. Hedrick</b>			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in by the funeral director, page 3 should be detached for use by the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

3233

NAME OF DECEASED JAMES J. JONES		SEX Male		AGE 35	
DATE OF DEATH April 1, 1956		PLACE OF DEATH Home		CITY Baltimore	
CAUSE OF DEATH Heart Disease		MANNER OF DEATH Natural		OCCUPATION None	
EDUCATION High School		RELIGION None		MARITAL STATUS Single	
BIRTH DATE April 1, 1921		BIRTH PLACE Maryland		FATHER'S NAME John J. Jones	
MOTHER'S NAME Mary J. Jones		FATHER'S OCCUPATION None		MOTHER'S OCCUPATION None	
FAMILY HISTORY None		PREVIOUS ILLNESS None		TREATMENT None	
SIGNATURE OF PHYSICIAN J. J. Jones		SIGNATURE OF DECEASED None		SIGNATURE OF WITNESSES None	
DATE OF SIGNATURE April 1, 1956		PLACE OF SIGNATURE Home		CITY Baltimore	
FEDERAL BUREAU OF INVESTIGATION None		STATE DEPARTMENT OF HEALTH None		LOCAL HEALTH DEPARTMENT None	

BUREAU V. S.

APR 2 1956

RECEIVED

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)  
SM 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
3234 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

03184  
Reg. Dist. No. 342

1. PLACE OF DEATH a. COUNTY Prince George's MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE Maryland b. COUNTY Prince George's					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cedar Heights Md		c. LENGTH OF STAY IN lb 12 years		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cedar Heights, Md.					
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 6037 K Street,.				d. STREET ADDRESS 6037 K Street,.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last Summie Long				4. DATE OF DEATH Month Day Year March 13, 19 56.					
5. SEX male	6. COLOR OR RACE colored	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH Dec 26, 1897		9. AGE (In years last birthday) 58 yrs.	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		10b. KIND OF BUSINESS OR INDUSTRY Construction		11. BIRTHPLACE (State or foreign country) Atlanta, Georgia		12. CITIZEN OF WHAT COUNTRY? U S A			
13. FATHER'S NAME John Long				14. MOTHER'S MAIDEN NAME Amanda Saunders					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. (If yes, give war or dates of service) 579-12-7446		17. INFORMANT Elizabeth Cook 2816 Wade Rd S. E. Washington, D. C.					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute congestive heart failure 442X DUE TO Cardiovascular renal disease Conditions, if any, which gave rise to immediate cause (b) (a), stating the underlying cause lost. DUE TO (c)								INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)								19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .									
ACTUAL SIGNATURE John T. Maloney M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/>				DATE SIGNED	
EXAMINER'S NAME (Type) John T. Maloney M. D.				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> March 13, 1956.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Remove		22b. DATE THEREOF 3/13/56		22c. NAME OF CEMETERY OR CREMATORY Swanton Hunter Funeral Home		22d. LOCATION (City, town, or county) (State) Washington D C			
23. FUNERAL DIRECTOR'S SIGNATURE F. Gaseh's Sons Hyattsville Md				24a. REC'D BY REGISTRAR DATE March 14 1956		24b. REGISTRAR'S SIGNATURE Carrie F. Campbell			



MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18  
 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. NAME OF DECEASED		2. SEX		3. AGE		4. RACE		5. DATE OF DEATH	
6. PLACE OF DEATH		7. OCCUPATION		8. CAUSE OF DEATH		9. MANNER OF DEATH		10. SIGNATURE OF EXAMINER	
11. SIGNATURE OF WITNESS		12. SIGNATURE OF WITNESS		13. SIGNATURE OF WITNESS		14. SIGNATURE OF WITNESS		15. SIGNATURE OF WITNESS	
16. SIGNATURE OF WITNESS		17. SIGNATURE OF WITNESS		18. SIGNATURE OF WITNESS		19. SIGNATURE OF WITNESS		20. SIGNATURE OF WITNESS	
21. SIGNATURE OF WITNESS		22. SIGNATURE OF WITNESS		23. SIGNATURE OF WITNESS		24. SIGNATURE OF WITNESS		25. SIGNATURE OF WITNESS	
26. SIGNATURE OF WITNESS		27. SIGNATURE OF WITNESS		28. SIGNATURE OF WITNESS		29. SIGNATURE OF WITNESS		30. SIGNATURE OF WITNESS	
31. SIGNATURE OF WITNESS		32. SIGNATURE OF WITNESS		33. SIGNATURE OF WITNESS		34. SIGNATURE OF WITNESS		35. SIGNATURE OF WITNESS	
36. SIGNATURE OF WITNESS		37. SIGNATURE OF WITNESS		38. SIGNATURE OF WITNESS		39. SIGNATURE OF WITNESS		40. SIGNATURE OF WITNESS	
41. SIGNATURE OF WITNESS		42. SIGNATURE OF WITNESS		43. SIGNATURE OF WITNESS		44. SIGNATURE OF WITNESS		45. SIGNATURE OF WITNESS	
46. SIGNATURE OF WITNESS		47. SIGNATURE OF WITNESS		48. SIGNATURE OF WITNESS		49. SIGNATURE OF WITNESS		50. SIGNATURE OF WITNESS	
51. SIGNATURE OF WITNESS		52. SIGNATURE OF WITNESS		53. SIGNATURE OF WITNESS		54. SIGNATURE OF WITNESS		55. SIGNATURE OF WITNESS	
56. SIGNATURE OF WITNESS		57. SIGNATURE OF WITNESS		58. SIGNATURE OF WITNESS		59. SIGNATURE OF WITNESS		60. SIGNATURE OF WITNESS	
61. SIGNATURE OF WITNESS		62. SIGNATURE OF WITNESS		63. SIGNATURE OF WITNESS		64. SIGNATURE OF WITNESS		65. SIGNATURE OF WITNESS	
66. SIGNATURE OF WITNESS		67. SIGNATURE OF WITNESS		68. SIGNATURE OF WITNESS		69. SIGNATURE OF WITNESS		70. SIGNATURE OF WITNESS	
71. SIGNATURE OF WITNESS		72. SIGNATURE OF WITNESS		73. SIGNATURE OF WITNESS		74. SIGNATURE OF WITNESS		75. SIGNATURE OF WITNESS	
76. SIGNATURE OF WITNESS		77. SIGNATURE OF WITNESS		78. SIGNATURE OF WITNESS		79. SIGNATURE OF WITNESS		80. SIGNATURE OF WITNESS	
81. SIGNATURE OF WITNESS		82. SIGNATURE OF WITNESS		83. SIGNATURE OF WITNESS		84. SIGNATURE OF WITNESS		85. SIGNATURE OF WITNESS	
86. SIGNATURE OF WITNESS		87. SIGNATURE OF WITNESS		88. SIGNATURE OF WITNESS		89. SIGNATURE OF WITNESS		90. SIGNATURE OF WITNESS	
91. SIGNATURE OF WITNESS		92. SIGNATURE OF WITNESS		93. SIGNATURE OF WITNESS		94. SIGNATURE OF WITNESS		95. SIGNATURE OF WITNESS	
96. SIGNATURE OF WITNESS		97. SIGNATURE OF WITNESS		98. SIGNATURE OF WITNESS		99. SIGNATURE OF WITNESS		100. SIGNATURE OF WITNESS	

RECEIVED  
 MAR 20 1956  
 BUREAU V. S.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in by the funeral director, page 3 should be detached for use in the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3187

## CERTIFICATE OF DEATH

Reg. Dist. No.

03185

1. PLACE OF DEATH a. COUNTY <u>Prince Georges'</u> MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Prince Georges'</u>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Chesley</u>		c. LENGTH OF STAY IN 1b <u>7 days</u>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>College Park</u> <u>14</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Prince Georges' General Hospital</u>			d. STREET ADDRESS <u>9736-51st Place</u>		
3. NAME OF DECEASED (Type or print) First <u>George</u> Middle <u>Martin</u> Last <u>Martin</u>			4. DATE OF DEATH Month <u>3</u> Day <u>3</u> Year <u>1956</u>		
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>4-30-</u>	9. AGE (In years last birthday) <u>80</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Night Watchman</u>		11. BIRTHPLACE (State or foreign country) <u>New York</u>	
13. FATHER'S NAME <u>George Martin</u>			14. MOTHER'S MAIDEN NAME <u>Unknown</u>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT <u>Statistic Card</u> Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>from torn of heart at street corner</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>generalized arteriosclerosis</u> DUE TO (c)					INTERVAL BETWEEN ONSET AND DEATH <u>2 weeks</u> <u>year</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>diabetes mellitus</u>					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)					
21. I certify that I attended the deceased from <u>2/25, 1956</u> to <u>3/3, 1956</u> , that I last saw the deceased alive on <u>3/3, 1956</u> , and that death occurred at <u>9:00 A.M.</u> , from the causes and on the date stated above.					
ACTUAL SIGNATURE <u>[Signature]</u>			DATE SIGNED <u>3-4-56</u>		
PHYSICIAN'S NAME (Type) <u>[Signature]</u>					
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>March 6, 1956</u>		22c. NAME OF CEMETERY OR CREMATORY <u>George Washington</u>	
22d. LOCATION (City, town, or county) <u>Hyattsville Md</u>		(State)			
23. FUNERAL DIRECTOR'S SIGNATURE <u>F Gasch's Sons</u>			ADDRESS <u>Hyattsville, Md.</u>		24a. REC'D BY REGISTRAR DATE <u>3/6/56</u>
24b. REGISTRAR'S SIGNATURE <u>[Signature]</u>					

RECEIVED

MAR 7 1956

BUREAU V. S.

1. NAME OF DECEASED		2. DATE OF DEATH		3. PLACE OF DEATH		4. CAUSE OF DEATH		5. MANNER OF DEATH		6. SEX		7. AGE		8. RACE		9. RELIGION		10. OCCUPATION		11. EDUCATION		12. MARITAL STATUS		13. SOCIAL STATUS		14. OTHER INFORMATION	

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

03186

3152

CERTIFICATE OF DEATH

Reg. Dist. No. 245

1. PLACE OF DEATH a. COUNTY <b>Prince Georges County</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>P. Geo.</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>15 Hyattsville</b>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hyattsville</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>00 6222 43rd Ave.</b>				d. STREET ADDRESS <b>6222 43rd Ave.</b>			
3. NAME OF DECEASED (Type or print) First Middle Last <b>Caroline Matha</b>				4. DATE OF DEATH Month Day Year <b>March 9, 1956</b>			
5. SEX <b>female</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>May 10, 1878</b>	9. AGE (In years last birthday) yrs. <b>77</b>	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Seamstress</b>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Pennsylvania</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Unknown</b>				14. MOTHER'S MAIDEN NAME <b>Unknown</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT Address <b>Hyattsville, Md</b> <b>Mrs. Howard Zahniser-6222 43rd Ave.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>200.0</b> <b>Memoria</b> DUE TO (b) <b>Round Cell Sarcoma of sciatic nerve</b> DUE TO (c) <b>3 mo</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.						INTERVAL BETWEEN ONSET AND DEATH <b>one week</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town)		(County) (State)	
21. I certify that I attended the deceased from <b>3/31/55</b> to <b>3/9/56</b> that I last saw the deceased alive on <b>3/3/56</b> , and that death occurred at <b>7:00 A.M.</b> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>1852 Columbia Rd N.W. Washington D.C.</b> DATE SIGNED <b>3/9/56</b> ACTUAL SIGNATURE <b>Horace H. Custis Jr.</b> PHYSICIAN'S NAME (Type) <b>HORACE H. CUSTIS JR</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Removal</b>		22b. DATE THEREOF <b>3/11/56</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Mt. Collins Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Tionesta, Pennsylvania</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>L. S. Davis Co</b>				24a. REC'D BY REGISTRAR <b>March 12 1956</b>		24b. REGISTRAR'S SIGNATURE <b>Mrs. Jas. S. Sorensen</b>	

CERTIFICATE OF DEATH

NAME OF DECEASED		SEX		AGE		DATE OF BIRTH		PLACE OF BIRTH		CITY OF BIRTH		STATE OF BIRTH		COUNTRY OF BIRTH	
JAMES EARL RAY		MALE		35		JAN 10, 1928		MEMPHIS, TENN.		MEMPHIS, TENN.		TENNESSEE		UNITED STATES	
RACE		COLOR		RELIGION		MARRIAGE		EDUCATION		OCCUPATION		CAUSE OF DEATH		MANNER OF DEATH	
WHITE		WHITE		METHODIST		MARRIED		HIGH SCHOOL		LABORER		HEART DISEASE		NATURAL	
DATE OF DEATH		PLACE OF DEATH		CITY OF DEATH		STATE OF DEATH		COUNTRY OF DEATH		DATE OF INTERMENT		PLACE OF INTERMENT		CITY OF INTERMENT	
JAN 25, 1968		MEMPHIS, TENN.		MEMPHIS, TENN.		TENNESSEE		UNITED STATES		JAN 25, 1968		MEMPHIS, TENN.		MEMPHIS, TENN.	
TIME OF DEATH		HOURS		MINUTES		AM		PM		DATE OF REPORT		PLACE OF REPORT		CITY OF REPORT	
10:00		10		00		AM		PM		JAN 25, 1968		MEMPHIS, TENN.		MEMPHIS, TENN.	
REPORTED BY		RELATIONSHIP		OCCUPATION		EDUCATION		CITY OF REPORT		STATE OF REPORT		COUNTRY OF REPORT		DATE OF REPORT	
DR. J. H. HARRIS		FATHER		LABORER		HIGH SCHOOL		MEMPHIS, TENN.		TENNESSEE		UNITED STATES		JAN 25, 1968	
SIGNATURE OF PHYSICIAN		DATE OF SIGNATURE		PLACE OF SIGNATURE		CITY OF SIGNATURE		STATE OF SIGNATURE		COUNTRY OF SIGNATURE		DATE OF SIGNATURE		PLACE OF SIGNATURE	
[Signature]		JAN 25, 1968		MEMPHIS, TENN.		MEMPHIS, TENN.		TENNESSEE		UNITED STATES		JAN 25, 1968		MEMPHIS, TENN.	

Remo

MAR 13 1968

RECEIVED

BUREAU V. 1

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

03187

## 3235 CERTIFICATE OF DEATH

Reg. Dist. No. 242

1. PLACE OF DEATH- COUNTY <u>Prince George</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <u>Maryland</u> COUNTY <u>Pr. George</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Rural</u>		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Rural</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>7701 Fort Foote Rd S.E.</u>		STREET ADDRESS (If rural, give location) <u>7701 Fort Foote Rd S.E.</u>	
3. NAME OF DECEASED (Type or Print) <u>Maggie Waters Mecon</u>	(First) (Middle) (Last)	4. DATE OF DEATH (Month) (Day) (Year) <u>March 9 1956</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE MARRIED, WIDOWED DIVORCED, (Specify) <u>WIDOWED</u>	8. DATE OF BIRTH <u>Sept. 13, 1868</u>
9. AGE last birthday <u>87</u> yrs.		10. If under 1 year (Months) (Days) (Hours) (Min.) <u>87</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>-</u>	
11. BIRTHPLACE (State or foreign country) <u>Murray Kentucky</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Jesse Spillman Waters</u>		14. MOTHER'S MAIDEN NAME <u>Martha Hutchinson</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY No. <u>No</u>	
17. INFORMANT <u>Martha Teuton</u>			

## 18. MEDICAL CERTIFICATION

## I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

## Immediate cause

(a) Carcinoma of the Rectum

INTERVAL BETWEEN ONSET AND DEATH

4 months

## Antecedent cause(s)

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last

(b) Myocardial Insufficiency5 yrs.(c) Bronchial AsthmaLife

## II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

Fracture of Left Hip Nov 1947" " Right Hip February 1951 (bedridden since)

19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
21. ACCIDENT SUICIDE HOMICIDE (Specify)		PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY		(CITY OR TOWN) (COUNTY) (STATE)	
TIME (Month) (Day) (Year) (Hour) OF INJURY		INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>		HOW DID INJURY OCCUR?	

22. I hereby certify that I attended the deceased from May, 1951, to March 9, 1956, that I last saw the deceased alive on March 9, 1956, and that death occurred at 9<sup>00</sup> p.m., from the causes and on the date stated above.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

Anna Coyne Todd, M.D.7519 Broadview Rd S.E.3-9-56

23. BURIAL CREMATION (REMOVAL) (Specify)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county)		(State)	
<u>3/10/56</u>		<u>3/10/56</u>		<u>Washington, D.C.</u>		<u>Washington, D.C.</u>		<u>D.C.</u>	
DATE REC'D BY LOCAL REG.		REGISTRAR'S SIGNATURE		24. FUNERAL DIRECTOR		ADDRESS			
<u>3/10/56</u>		<u>Carrie Campbell</u>		<u>Walter Funeral Home 741 E. 1st St. S.E.</u>		<u>Washington, D.C.</u>			

RECEIVED

MAY 15 1956

BUREAU V. S.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3188

CERTIFICATE OF DEATH

Reg. Dist. No.

03188

03188

1. PLACE OF DEATH a. COUNTY <u>PRINCE GEORGE'S</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>PRINCE GEORGE'S</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>38 Cheverly</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hyattsville</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>77 Prince Georges GEN. Hosp.</u>				d. STREET ADDRESS <u>7611-23rd. Ave</u>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>Scott BIGGER Miller</u>				4. DATE OF DEATH Month Day Year <u>March 11 1956</u>			
5. SEX <u>M</u>	6. COLOR OR RACE <u>W.</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>8-21-98</u>	9. AGE (In years last birthday) <u>57</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Scheme Tech Postal service U S Government</u>				11. BIRTHPLACE (State or foreign country) <u>N. Carolina</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S. A.</u>	
13. FATHER'S NAME <u>Monroe Miller</u>				14. MOTHER'S MAIDEN NAME <u>Margaret Mc Connell</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. (If yes, give war or dates of service)		17. INFORMANT Address <u>Hospital records Cheverly, Maryland.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Heart attack Ca. brain</u> <u>162X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Bronchopneumonia Ca</u> DUE TO (c) _____							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>4-2</u> , 19 <u>42</u> to <u>3-11</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>3-10</u> , 19 <u>56</u> , and that death occurred at _____ M, from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>A. Deitz</u>				ADDRESS (Street, city or town, state) <u>4314 Gellert St. Hyattsville, Md.</u>			
DATE SIGNED <u>3-11-56</u>							
PHYSICIAN'S NAME (Type) <u>AARON Deitz</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>3/13/56</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Fort Lincoln Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Colmar Manor, Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>F. Gasch's Sons</u>				ADDRESS <u>Hyattsville, Maryland.</u>		24a. REC'D BY REGISTRAR DATE <u>3/12/56</u>	
				24b. REGISTRAR'S SIGNATURE <u>Roma de Lounney</u>			

CERTIFICATE OF DEATH

1. NAME OF DECEASED		2. SEX		3. AGE		4. RACE		5. BIRTH DATE		6. BIRTH PLACE		7. MARRIAGE DATE		8. OCCUPATION		9. CAUSE OF DEATH		10. PLACE OF DEATH		11. TIME OF DEATH		12. SIGNATURE OF PHYSICIAN		13. SIGNATURE OF REGISTRAR		14. SIGNATURE OF WITNESSES			
JAMES H. HIGGINS		M		45		W		1890		BALTIMORE, MD		1915		Carpenter		Heart Disease		Home		10:00 AM		J. H. Higgins		J. H. Higgins		J. H. Higgins			
15. PLACE OF BIRTH		16. DATE OF DEATH		17. TIME OF DEATH		18. SIGNATURE OF PHYSICIAN		19. SIGNATURE OF REGISTRAR		20. SIGNATURE OF WITNESSES		21. SIGNATURE OF PHYSICIAN		22. SIGNATURE OF REGISTRAR		23. SIGNATURE OF WITNESSES		24. SIGNATURE OF PHYSICIAN		25. SIGNATURE OF REGISTRAR		26. SIGNATURE OF WITNESSES		27. SIGNATURE OF PHYSICIAN		28. SIGNATURE OF REGISTRAR		29. SIGNATURE OF WITNESSES	
BALTIMORE, MD		1936		10:00 AM		J. H. Higgins		J. H. Higgins		J. H. Higgins		J. H. Higgins		J. H. Higgins		J. H. Higgins		J. H. Higgins		J. H. Higgins		J. H. Higgins		J. H. Higgins		J. H. Higgins		J. H. Higgins	

BUREAU V. S.

MAR 14 1936

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

03189

3189

CERTIFICATE OF DEATH

Reg. Dist. No.

231

1. PLACE OF DEATH a. COUNTY <u>Prince Georges</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Prince Georges</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Chewery</u>				c. LENGTH OF STAY IN 1b <u>2 days</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>3502 Upshon Street 34</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Prince Georges General Hospital</u>				d. STREET ADDRESS <u>Brentwood</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Sophia</u> Middle <u>A.</u> Last <u>Mollohan</u>				4. DATE OF DEATH Month <u>3</u> Day <u>25</u> Year <u>19 56</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>July 12th / 81</u>	
				9. AGE (In years last birthday) <u>74</u> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>at home</u>		11. BIRTHPLACE (State or foreign country) <u>Virginia</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>							
13. FATHER'S NAME <u>Martin Click</u>				14. MOTHER'S MAIDEN NAME <u>Catherine Turner</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT <u>Statistic Card</u> Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>443X Cardiac decompensation</u> DUE TO (b) <u>Acute Left Bundle Branch Block</u> DUE TO (c) <u>Hypertensive Arteriosclerotic Ht. Disease 10 years</u> CONDITIONS, IF ANY, WHICH GAVE RISE TO IMMEDIATE CAUSE (a), stating the underlying cause last.							INTERVAL BETWEEN ONSET AND DEATH <u>3 days</u> <u>3 days</u> <u>10 years</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <u>July</u> , 19 <u>56</u> to <u>3/23</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>3/23</u> , 19 <u>56</u> , and that death occurred at <u>3:45 P.M.</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Leon L. Gallin</u>				M.D. <u>3827-34th St., Mt Rainier</u>			
PHYSICIAN'S NAME (Type) <u>LEON L. GALLIN</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>3/26/56</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Fort Lincoln Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Belmar Manor, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Galley's Funeral Home Mt. Rainier</u>				ADDRESS <u>3200-84 Ave</u>		24a. REC'D BY REGISTRAR DATE <u>3/25/56</u>	
				24b. REGISTRAR'S SIGNATURE <u>Claytona Downing</u>			

# CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 12

Reg. No. 10

MARRIAGE

A.

181

Martin Chick  
 Catherine Turner

BUREAU V. E.

MAR 27 1956

RECEIVED

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please excuse the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for our files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3236

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

03190

Reg. Dist. No. 242

1. PLACE OF DEATH a. COUNTY Prince George's MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE Maryland b. COUNTY Prince George's		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Largo		c. LENGTH OF STAY IN 1b 3 months		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Largo	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Lottsford Road			d. STREET ADDRESS Lottsford Road		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Middle Last Carrie Virginia Morgal			4. DATE OF DEATH Month Day Year March 28 1956		
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH October 3, 1878	9. AGE (In years last birthday) 77 yrs.	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Own home.		11. BIRTHPLACE (State or foreign country) Maryland	
13. FATHER'S NAME John Thomas Simpson			14. MOTHER'S MAIDEN NAME Annie K. Chaney		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. (If yes, give war or dates of service) None		17. INFORMANT Address Joseph E. Morgal Landover, Maryland.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute congestive heart failure 442X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Cardiovascular renal disease. DUE TO (c)					INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .					
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 3/31/1956		22c. NAME OF CEMETERY OR CREMATORY Washington Nat'l Cem.	
23. FUNERAL DIRECTOR'S SIGNATURE W.W.Chambers Company, Riverdale, Md.		ADDRESS		24a. REC'D BY REGISTRAR DATE 3-30-56	
24b. REGISTRAR'S SIGNATURE Carrie Campbell		DATE		24c. REGISTRAR'S SIGNATURE	



ILLINOIS STATE DEPARTMENT OF HEALTH - BUREAU OF  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

NAME OF DECEASED		SEX		AGE		DATE OF DEATH	
PLACE OF DEATH		CITY		COUNTY		STATE	
OCCUPATION		EDUCATION		MARRIAGE		RELIGION	
CAUSE OF DEATH		MANNER OF DEATH		DISEASE		SYMPTOMS	
HISTORY		PHYSICAL EXAMINATION		LABORATORY EXAMINATION		POSTMORTEM EXAMINATION	
FINDINGS		CONCLUSIONS		REMARKS		SIGNATURE OF EXAMINER	
DATE OF EXAMINATION		PLACE OF EXAMINATION		CITY		COUNTY	
STATE		FEDERAL BUREAU OF INVESTIGATION		U.S. DEPARTMENT OF JUSTICE		WASHINGTON, D.C.	

BUREAU V. S.

APR 3 1956

RECEIVED



# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3196

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

03191

Reg. Dist. No. 237

<b>1. PLACE OF DEATH</b> a. COUNTY <u>Prince Georges</u> <b>MARYLAND</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cheverly</u> c. LENGTH OF STAY IN 1b <u>D.O.G.</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Prince Georges General Hosp</u>				<b>2. USUAL RESIDENCE</b> (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Pr. Georges</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Lanham</u> d. STREET ADDRESS <u>Box 28 - Route 2</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
<b>3. NAME OF DECEASED</b> (Type or print) <u>John</u> First <u>Archibald Moriarty</u> Middle Last		<b>4. DATE OF DEATH</b> Month <u>3</u> - Day <u>23</u> Year <u>1956</u>		<b>5. SEX</b> <u>male</u>		<b>6. COLOR OR RACE</b> <u>white</u>		<b>7. MARRIED</b> <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> <b>8. DATE OF BIRTH</b> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> <u>4-5-82</u>		<b>9. AGE</b> (In years last birthday) <u>73</u> yrs. <b>IF UNDER 1 YEAR</b> Months Days Hours Min.	
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>Retired</u> <b>10b. KIND OF BUSINESS OR INDUSTRY</b> <u>Attorney</u>				<b>11. BIRTHPLACE</b> (State or foreign country) <u>Washington D.C.</u> <b>12. CITIZEN OF WHAT COUNTRY?</b> <u>U.S.A.</u>							
<b>13. FATHER'S NAME</b> <u>John H. Moriarty</u>				<b>14. MOTHER'S MAIDEN NAME</b> <u>Bertha Sullivan</u>							
<b>15. WAS DECEASED EVER IN U. S. ARMED FORCES?</b> (Yes, no, or unknown)				<b>16. SOCIAL SECURITY NO.</b>				<b>17. INFORMANT</b> Address <u>Margaret Buchtell 2700 Conn. Ave. D.C.</u>			
<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Gente congestive heart failure</u> DUE TO (b) <u>Pulmonary tuberculosis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Hyperthyroidism</u>											
<b>19. WAS AUTOPSY PERFORMED?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
<b>20a. EXTERNAL CAUSE WAS PRIMARY</b> <input type="checkbox"/> <b>CONTRIBUTING</b> <input checked="" type="checkbox"/> <b>CAUSE OF DEATH.</b>				<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.)							
<b>20c. TIME OF INJURY</b> Month, Day, Year Hour o. m. p. m. <u>19</u>				<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.)		<b>20f. (City or town)</b>		<b>(County)</b> <b>(State)</b>	
<b>21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/>, Inspection <input checked="" type="checkbox"/>, Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/>, Accident <input type="checkbox"/>, Suicide <input type="checkbox"/>, Homicide <input type="checkbox"/>, Undetermined cause <input type="checkbox"/>.</b>											
<b>ACTUAL SIGNATURE</b> <u>John J. Maloney</u> <b>M.D.</b>						<b>CHIEF MEDICAL EXAMINER</b> <input type="checkbox"/>					
<b>EXAMINER'S NAME (Type)</b> <u>JOHN T. MALONEY - M.D.</u>						<b>ASSISTANT MEDICAL EXAMINER</b> <input type="checkbox"/>					
<b>DEPUTY MEDICAL EXAMINER</b> <input checked="" type="checkbox"/>						<b>DATE SIGNED</b> <u>Mar. 23, 1956.</u>					
<b>22a. BURIAL, CREMATION, REMOVAL (Specify)</b> <u>Burial</u>				<b>22b. DATE THEREOF</b> <u>3/26/56</u>		<b>22c. NAME OF CEMETERY OR CREMATORY</b> <u>Mt. Olivet Cemetery</u>				<b>22d. LOCATION</b> (City, town, or county) (State) <u>Washington D.C.</u>	
<b>23. FUNERAL DIRECTOR'S SIGNATURE</b> <u>Malley's Funeral Home</u>						<b>ADDRESS</b> <u>5290 - R.I. Ave. Mt. Rainier, Md.</u>		<b>24a. READ BY REGISTRAR</b>		<b>24b. REGISTRAR'S SIGNATURE</b> <u>Wm. C. Doane</u>	
<b>DATE</b> <u>3/25/56</u>						<b>DATE</b>					

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained in your files. File Pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 12  
 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

NAME OF DECEASED		AGE		SEX		RACE		DATE OF BIRTH		PLACE OF BIRTH	
RESIDENCE		OCCUPATION		EDUCATION		MARRIAGE		MILITARY SERVICE		PREVIOUS ILLNESS	
DATE OF DEATH		TIME OF DEATH		PLACE OF DEATH		CAUSE OF DEATH		MANNER OF DEATH		SIGNATURE OF EXAMINER	
FAMILY HISTORY		SOCIAL HISTORY		HISTORY OF PRESENT ILLNESS		POST-MORTEM EXAMINATION		LABORATORY EXAMINATIONS		OTHER INFORMATION	

BUREAU V. S.

MAR 27 1956

RECEIVED

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

03192

## 3191 CERTIFICATE OF DEATH

Reg. Dist. No. 231

1. PLACE OF DEATH COUNTY <u>Prince Georges</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>Maryland</u> COUNTY <u>Pr. Georges</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Bladensburg</u>		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Bladensburg</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>4903 Newton Street</u>		STREET ADDRESS (If rural give location) <u>4903 Newton Street</u>	
3. NAME OF DECEASED (Type or Print)	(First)	(Middle)	(Last)
<u>Elsie</u>	<u>Gertrude</u>	<u>Nalley</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>white</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>married</u>	8. DATE OF BIRTH <u>11/13/1889</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>	10b. KIND OF BUSINESS OR INDUSTRY <u>own home</u>	9. AGE last birthday <u>66</u> yrs.	4. DATE OF DEATH (Month) <u>3</u> (Day) <u>10</u> (Year) <u>1956</u>
11. BIRTHPLACE (State or foreign country) <u>Washington, D.C.</u>	12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	13. FATHER'S NAME <u>Cornelius D. Willis</u>	
14. MOTHER'S MAIDEN NAME <u>Minerva Sears</u>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes, give war or dates of service)	
16. SOCIAL SECURITY No. <u>577-01-5477</u>		17. INFORMANT <u>William E. Nalley, Son</u>	

## 18. MEDICAL CERTIFICATION

## I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

## Immediate cause

(a) Pulmonary Edema + Hemorrhage

INTERVAL BETWEEN ONSET AND DEATH

24 hrs

## Antecedent cause(s)

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last

(b) Squamous Cell Carcinoma of Lung1 year +

(c)

## II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

## 19a. DATE OF OPERATION 19b. MAJOR FINDINGS OF OPERATION

## 20. AUTOPSY?

Yes ☐ No ☐ (STATE)

21. ACCIDENT (Specify)	PLACE (Home, farm, factory, street, OF office bldg., etc.)	(CITY OR TOWN)	(COUNTY)
SUICIDE HOMICIDE	INJURY		
TIME (Month) (Day) (Year) (Hour)	INJURY OCCURRED While at Not While	HOW DID INJURY OCCUR?	
OF INJURY	m. Work <input type="checkbox"/> At work <input type="checkbox"/>		

22. I hereby certify that I attended the deceased from 5-5....., 1955., to 3-10....., 1956., that I last saw the deceasedalive on 3-10....., 1956., and that death occurred at 10:50 P.m., from the causes and on the date stated above.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

23. BURIAL, CREMATION REMOVAL (Specify)	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county)	(State)
<u>Burial</u>	<u>3/14/56</u>	<u>Fort Lincoln</u>	<u>Colmar Manor, Md.</u>	<u>3-11-56</u>
DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS	
<u>March 13, 1956</u>	<u>Amanda Downey</u>	<u>Walley's Funeral Home, Inc.</u>	<u>3200 R.I. Ave.</u>	
<u>3/15/56</u>		<u>Wt. Rainier, Md.</u>		

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

MAR 20 1956

BUREAU V. S.

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4  
 may be retained by the hospital. The attending physician and completed certificate has been signed by the attending physician and completed in the presence of the funeral director. After this certificate has been signed by the attending physician and completed in the presence of the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3192

## CERTIFICATE OF DEATH

03193

Reg. Dist. No. 251

1. PLACE OF DEATH a. COUNTY Prince George's MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Prince Georges			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 38 Cheverly, Md.				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Villa Heights			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 77 Prince George's General Hospital				d. STREET ADDRESS 5507 Landover, Md.			
3. NAME OF DECEASED (Type or print) First Middle Last Francis Newkirk				4. DATE OF DEATH Month Day Year March 26, 19 56.			
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Dec 16, 1901		9. AGE (In years last birthday) 54 yrs.	10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Photographer				10b. KIND OF BUSINESS OR INDUSTRY Army Map service		11. BIRTHPLACE (State or foreign country) Michigan	
13. FATHER'S NAME Frank Newkirk				14. MOTHER'S MAIDEN NAME Unknown			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO.		17. INFORMANT Address Della V. Newkirk Villa Heights Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.1 Acute Coronary Arteriosclerosis DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Coronary Arteriosclerosis DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							INTERVAL BETWEEN ONSET AND DEATH
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 2-4, 1946, to 3-26, 1956, that I last saw the deceased alive on 3-23, 1956, and that death occurred at M, from the causes and on the date stated above.							
ACTUAL SIGNATURE Aaron Deitz, M.D.				DATE SIGNED 3-27-56			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Dec 29, 1956		22c. NAME OF CEMETERY OR CREMATORY Fort Lincoln Cemetery		22d. LOCATION (City, town, or county) (State) Colmar Manor Md.	
23. FUNERAL DIRECTOR'S SIGNATURE F. Gasch's Sons				ADDRESS Hyattsville, Md.		24a. REC'D BY REGISTRAR DATE 3/27/56	
				24b. REGISTRAR'S SIGNATURE Amanda Lounney			

9561 62 877

RECEIVED



1

INSTRUCTIONS

**TO ATTENDING PHYSICIAN OF HOSPITAL:** The law requires that the death certificate be executed within **24 hours** after death. The bottom copy may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A13C 1-55 10M

## MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

3193 **CERTIFICATE OF DEATH**

03194 239

Reg. Dist. No. 29

<b>1. PLACE OF DEATH</b>				<b>2. USUAL RESIDENCE (HOME) OF DECEASED</b>			
COUNTY <b>Prince George</b>		STATE <b>Maryland</b>		COUNTY <b>Prince George</b>			
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <b>Laurel</b>		LENGTH OF STAY (in this place) <b>2 years</b>		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <b>Laurel</b>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <b>920 Park Hill Road</b>				STREET ADDRESS (If rural give location) <b>920 Park Hill Road</b>			
<b>3. NAME OF DECEASED</b> (First) (Middle) (Last) <b>HENRY CHASE NEWMAN</b>				<b>4. DATE OF DEATH</b> (Month) (Day) (Year) <b>March 5 19 56</b>			
<b>5. SEX</b> <b>Male</b>	<b>6. COLOR OR RACE</b> <b>White</b>	<b>7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)</b> <b>NA</b>	<b>8. DATE OF BIRTH</b> <b>25 Sept 1947</b>		<b>9. AGE last birthday</b> <b>8 yrs.</b>	<b>IF UNDER 1 YEAR</b> Months Days Hours Min.	
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <b>none</b>		<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <b>none</b>		<b>11. BIRTHPLACE</b> (State or foreign country) <b>Ashville, New Carolina</b>		<b>12. CITIZEN OF WHAT COUNTRY?</b> <b>USA</b>	
<b>13. FATHER'S NAME</b> <b>Henry Chase Newman</b>				<b>14. MOTHER'S MAIDEN NAME</b> <b>Daisy B. Hamilton</b>			
<b>15. WAS DECEASED EVER IN U. S. ARMED FORCES?</b> (Yes, no, or unk.) <b>no</b>		<b>16. SOCIAL SECURITY NO.</b> <b>none</b>		<b>17. INFORMANT &amp; ADDRESS</b> <b>Father: Henry Chase, 920 Park Hill Road, Laurel, Md.</b>			
<b>I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH</b>				<b>18. MEDICAL CERTIFICATION</b>			
<b>2044 IMMEDIATE CAUSE (A)</b> <b>ANTECEDENT CAUSE(S) DUE TO</b>				<b>Cerebral hemorrhage</b>			
<b>DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE</b>				<b>leukemic infiltrates</b>			
<b>STATING UNDERLYING CAUSE LAST.</b>				<b>leukemia</b>			
<b>II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.</b>				<b>INTERVAL BETWEEN ONSET AND DEATH</b> <b>1/2 hr</b> <b>2 yrs</b> <b>2 yrs</b>			
<b>19a. DATE OF OPERATION</b>		<b>19b. MAJOR FINDINGS OF OPERATION</b>		<b>20. AUTOPSY?</b> YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
<b>21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)</b>		<b>21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)</b>		<b>21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)</b>			
<b>21d. TIME OF INJURY (Month) (Day) (Year) (Hour)</b>		<b>21a. INJURY OCCURRED While at work Not while at work</b>		<b>21f. HOW DID INJURY OCCUR?</b>			
<b>22. I hereby certify that I attended the deceased from Aug 1955, to Feb 1956, that I last saw the deceased alive on 29 Feb 1956, and that death occurred at 2020 M, from the causes and on the date stated above.</b>							
<b>SIGNATURE</b> <b>Seymour E. Wheelock, Capt., MC</b>				<b>ADDRESS (Street, city, town, state)</b> <b>Walter Reed Army Hospital, Wash DC</b>			
<b>DATE SIGNED</b> <b>6 Mar 56</b>				<b>DATE SIGNED</b> <b>6 Mar 56</b>			
<b>23. BURIAL, CREMATION, REMOVAL (SPECIFY)</b> <b>Burial</b>		<b>DATE THEREOF</b> <b>13-9-56</b>		<b>NAME OF CEMETERY OR CREMATORY</b> <b>Oakdale Cemetery</b>		<b>LOCATION (City, town, or county) (State)</b> <b>Hendersonville, N.C.</b>	
<b>24. REC'D BY REGISTRAR</b> <b>6 Mar 56</b>		<b>REGISTRAR'S SIGNATURE</b> <b>WILLIAM L. SAYLOR, 1/Lt MSC</b>		<b>25. FUNERAL DIRECTOR'S SIGNATURE</b> <b>Donaldson Funeral Home, Laurel, Md.</b>		<b>ADDRESS</b>	

BUREAU V. S.

MAR 12 1956

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# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

3237

## CERTIFICATE OF DEATH

03195

Reg. Dist. No. 283

1. PLACE OF DEATH COUNTY <u>Prince Georges</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>D. C.</u> COUNTY <u>-</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Glenn Dale (rural)</u> LENGTH OF STAY (in this place) <u>7 mo., &amp; 15 days</u>		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Washington</u> <u>478-3</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Glenn Dale Hospital</u>		STREET ADDRESS (If rural, give location) <u>1220 Missouri Ave., N. W.</u>	
3. NAME OF DECEASED (First) (Middle) (Last) <u>GEORGE N. NICHOLSON</u>		4. DATE OF DEATH (Month) (Day) (Year) <u>3 25 1956</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Married</u>	8. DATE OF BIRTH <u>1/28/1894</u>
9. AGE last birthday <u>62</u> yrs.		10. If under 1 year 1 year 1 year Months Days Hours Min. <u>1 20 - -</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Truckster</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Self-employed</u>	
11. BIRTHPLACE (State or foreign country) <u>Greece</u>		12. CITIZEN OF WHAT COUNTRY? <u>Unknown</u> ✓	
13. FATHER'S NAME <u>Nicholas Nicholson</u>		14. MOTHER'S MAIDEN NAME <u>Evelyn Karasotas</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If year, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY No. <u>None</u>	
17. INFORMANT AND ADDRESS <u>Decedent</u>			

18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		
162x Immediate cause (a) <u>bronchogenic carcinoma left lung</u>		<u>4 months</u>
Antecedent cause(s) (b) <u>1002x Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last</u>		
II. OTHER SIGNIFICANT CONDITIONS (c) <u>Pulmonary Tuberculosis</u>		<u>14 months</u>
19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
21. ACCIDENT (Specify) SUICIDE HOMICIDE	PLACE (Home, farm, factory, street, office bldg., etc.) INJURY	(CITY OR TOWN) (COUNTY) (STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 8/10, 1955, to 3/25, 1956, that I last saw the deceased alive on 3/24, 1956, and that death occurred at 2:15 P.m., from the causes and on the date stated above.

SIGNATURE <u>Francis DeCosta M.D.</u>	(Degree or title)	ADDRESS <u>Glenn Dale Md.</u>	DATE SIGNED <u>3/26/56</u>
23. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	DATE <u>3/28/56</u>	NAME OF CEMETERY OR CREMATORY <u>Cedar Hill</u>	LOCATION (City, town, or county) (State) <u>Prince Georges Md.</u>
DATE REC'D BY LOCAL REG. <u>3/26/56</u>	REGISTRAR'S SIGNATURE <u>Woe Weiss</u>	24. FUNERAL DIRECTOR <u>SH Hines</u>	ADDRESS <u>14th St Washington DC</u>

MARGIN RESERVED FOR BINDING

VS. A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

APR 4 1956

BUREAU V. S.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.  
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)  
SM 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
3238 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

03196

Reg. Dist. No. 230

1. PLACE OF DEATH a. COUNTY Prince George's MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Prince George's			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Beltsville Maryland		c. LENGTH OF STAY IN 1b 3 years		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Laurel, Maryland			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Baker's Nursing Home				d. STREET ADDRESS R. F. D. 2		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last Margaret Nicholson				4. DATE OF DEATH Month Day Year March 17, 1956- 19			
5. SEX female		6. COLOR OR RACE white		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Sept 29, 1875	
9. AGE (In years last birthday) 80 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House wife		10b. KIND OF BUSINESS OR INDUSTRY at home		11. BIRTHPLACE (State or foreign country) Wisconsin		12. CITIZEN OF WHAT COUNTRY? U S A	
13. FATHER'S NAME Niles Nicholson				14. MOTHER'S MAIDEN NAME Unknown			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. no		17. INFORMANT Address William A Flester R. F. D. 2 Laurel, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute congestive heart failure</u> 442X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Cardiovascular renal disease</u> DUE TO (c) <u>Arteriosclerosis</u>						INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (o)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <u>John T. Maloney</u> EXAMINER'S NAME (Type) John T. Maloney				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
DATE SIGNED March 17, 1956.							
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF Mar 19-56		22c. NAME OF CEMETERY OR CREMATORY Guy Hill		22d. LOCATION (City, town, or county) (State) Laurel P. G. Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Bert R. ...				ADDRESS Laurel Md.		24a. REC'D BY REGISTRAR DATE March 21-56	
						24b. REGISTRAR'S SIGNATURE John D. Smith	





3239

## CERTIFICATE OF DEATH

Reg. Dist. No. 143

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY Prince Georges		MARYLAND		STATE D. C.		COUNTY	
CITY (If outside corporate limits, write RURAL OR and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN		Washington 47X-3	
X TOWN Glenn Dale (rural)		2 yrs., 5 mo. & 17 days		STREET ADDRESS (If rural give location)		1123 3rd St., S. W.	
HOSPITAL OR INSTITUTION OR STREET ADDRESS Glenn Dale Hospital							
3. NAME OF DECEASED: (First) Stanley		(Middle)		(Last) Norris		4. DATE OF DEATH: March 2 1956	
5. SEX: Male		6. COLOR OR RACE: Negro		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Married		8. DATE OF BIRTH: Jul. 7, 1909	
9. AGE last birthday: 46 yrs.		10. MONTHS: 7		11. DAYS: 24		12. HOURS: 2	
10a. USUAL OCCUPATION. Give kind of work done during most of working life, even if retired: Laborer		10b. KIND OF BUSINESS OR INDUSTRY: Comm. Office Furniture Co.		11. BIRTHPLACE (State or foreign country): Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME: Frank Norris				14. MOTHER'S MAIDEN NAME: Alice Gladden			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) No		16. SOCIAL SECURITY No.: 578-14-5915		17. INFORMANT & ADDRESS: Decedent			
18. MEDICAL CERTIFICATION							
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				Interval Between Onset And Death			
Immediate cause (a) Pulmonary hemorrhage				One day			
Antecedent causes (s) (b) Pulmonary tuberculosis				44 yrs 6 mos			
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last. (c)							
11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.							
19a. DATE OF OPERATION:				19b. MAJOR FINDINGS OF OPERATION			
21. ACCIDENT SUICIDE HOMICIDE (Specify)				PLACE (Home, farm, factory, street, OF office bldg., etc.)		(CITY OR TOWN) (COUNTY) (STATE)	
TIME (Month) (Day) (Year) (Hour) OF INJURY		INJURY OCCURRED While at Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from A. 14, 1953, to 3. 2, 1956 that I last saw the deceased alive on 3. 2, 1956, and that death occurred at 9:45 A.M. from the causes and on the date stated above.							
SIGNATURE Daniel Leo Pinescane		(Degree or title) M. D.		Glenn Dale Hospital Glenn Dale, Maryland		DATE SIGNED 3/2/56	
23. BURIAL, CREMATION, REMOVAL (Specify) Removal		DATE THEREOF 3/2/56		NAME OF CEMETERY OR CREMATORY Hto Washington		(State) D.C.	
DATE REC'D BY LOCAL REGISTRAR 3/2/56		REGISTRAR'S SIGNATURE Wm Green		24. FUNERAL DIRECTOR Barnes Matthews		ADDRESS 614-4th St SW	

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

MAR 7 1956

BUREAU V. S.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it should be filed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)  
ISM 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 7, Film G195 4-6-56 et

3153

CERTIFICATE OF DEATH

03198

Reg. Dist. No.

245

1. PLACE OF DEATH o. COUNTY Prince George's MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Prince Georges	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 15 Hyattsville, Md		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 15 Hyattsville, Md.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 6111 Queens Chapel Road		d. STREET ADDRESS 6111 Queens Chapel Rd	
3. NAME OF DECEASED (Type or print) First Robert Middle Elliott Last Padgett		4. DATE OF DEATH Month March Day 31, Year 19 56.	
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Jan 20, 1936
9. AGE (In years lost birthday) yrs. 20		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Newark New Jersey		12. CITIZEN OF WHAT COUNTRY? U S A	
13. FATHER'S NAME Carl R. Padgett		14. MOTHER'S MAIDEN NAME Della Bloodworth	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. none	
17. INFORMANT Carl R. Padgett		6111 Queens Chapel Rd Hyattsville, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 483X Post influenza meningitis - right side DUE TO (b) pneumonia DUE TO (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.		INTERVAL BETWEEN ONSET AND DEATH 5 days 12 days	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. p. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 3-26-56, 19, to 3-31-56, 19, that I last saw the deceased alive on 3-30-56, 19, and that death occurred at 5 <sup>00</sup> A M, from the causes and on the date stated above.			
ACTUAL SIGNATURE John P. Clum M.D.		ADDRESS (Street, city or town, state) 6110 43rd Ave DATE SIGNED 3-31-56	
PHYSICIAN'S NAME (Type) Dr. John C. Clum		Hyattsville, Md.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 4/2/56	
22c. NAME OF CEMETERY OR CREMATORY Fort Lincoln Cemetery		22d. LOCATION (City, town, or county) (State) Colmar Manor, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE F. Gasch's Sons		ADDRESS Hyattsville, Maryland.	
24a. REC'D BY REGISTRAR DATE April 7 1956		24b. REGISTRAR'S SIGNATURE Severe	

BUREAU V. S.

APR 4 1956

RECEIVED

03199

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3240

## CERTIFICATE OF DEATH

Reg. Dist. No. 244

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY <u>Prince Georges</u> MARYLAND		STATE <u>Minnesota</u> COUNTY <u>Unk</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Andrews AFB, Wash 25, DC</u>		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Minneapolis</u> <u>60X-3</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>1401st USAF Hospital, MATS Andrews AFB, Wash 25, D.C.</u>		STREET ADDRESS (If rural give location) <u>3111 12th Avenue South</u>	
3. NAME OF DECEASED: (First) (Middle) (Last) (Type or Print) <u>Donald R Patterson</u>		4. DATE (Month) (Day) (Year) OF DEATH: <u>March 30 19 56</u>	
5. SEX: <u>Male</u>	6. COLOR OR RACE: <u>Cau</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>Married</u>	8. DATE OF BIRTH: <u>12 July 1905</u>
9. AGE last birthday <u>50</u> yrs.		10. IF UNDER 1 YEAR Months Days	11. IF UNDER 24 HRS Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):		10B. KIND OF BUSINESS OR INDUSTRY: <u>US Army</u>	11. BIRTHPLACE (State or foreign country): <u>Iowa</u>
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		13. FATHER'S NAME: <u>Roy S. Patterson</u>	
14. MOTHER'S MAIDEN NAME: <u>May B. Williams</u>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) <u>✓</u>	
16. SOCIAL SECURITY NO. <u>Unknown</u>		17. INFORMANT & ADDRESS: <u>US Army Military Records</u>	
18. MEDICAL CERTIFICATION			INTERVAL BETWEEN ONSET AND DEATH
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			
IMMEDIATE CAUSE (A) <u>330X Subarachnoid hemorrhage</u>			<u>95 Minutes</u>
DUE TO			
ANTECEDENT CAUSE (B) <u>cause undetermined pending autopsy</u>			
DUE TO			
(C)			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
19A. DATE OF OPERATION: <u>2</u>		19B. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	
21C. WHERE DID (City or town) (County) (State)		21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	
21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <u>30 Mar., 1956</u> , to <u>30 Mar., 1956</u> that I last saw the deceased alive on <u>30 March., 1956</u> , and that death occurred at <u>8:55PM</u> , from the causes and on the date stated above.			
SIGNATURE <u>Anthony J. Palazzolo</u>		ADDRESS <u>M. D. 1401st USAF Hospital, AAFB</u>	
DATE SIGNED <u>30 March 1956</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>4-3-56</u>	
NAME OF CEMETERY OR CREMATORY <u>Arlington National Cem.</u>		LOCATION (City, town, or county) (State) <u>Fort Myer, Va.</u>	
DATE REC'D BY LOCAL REGISTRAR <u>2 April 56</u>		REGISTRAR'S SIGNATURE <u>(Mrs) Helen M. Michalec</u>	
24. FUNERAL DIRECTOR <u>816 "H" St.,</u>		ADDRESS <u>Rinaldi Funeral Home, Inc., Wash., D C.</u>	

MARGIN RESERVED FOR BINDING

VS. A15 — 10 - 53

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BUREAU V. S.

APR 6 1956

RECEIVED



TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained in your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

# 3194 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

03200

Reg. Dist. No. 231

1. PLACE OF DEATH a. COUNTY <b>Prince Georges</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Pr. Geo.</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>38 Cheverly</b>		c. LENGTH OF STAY IN 1b <b>70 days</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Riverdale 25</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>17 Prince Georges General Hosp.</b>				d. STREET ADDRESS <b>5417 Powhatan Road</b>			
3. NAME OF DECEASED (Type or print) First <b>Birdie</b> Middle <b>Pearl</b> Last <b>Pickett</b>				4. DATE OF DEATH Month <b>March</b> Day <b>4</b> Year <b>1956</b>			
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Dec. 17, 1876</b>		9. AGE (In years last birthday) <b>79</b> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>None</b>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Texas</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Harry Sutton</b>				14. MOTHER'S MAIDEN NAME <b>Fannie Ryan</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO.		17. INFORMANT <b>Mrs. Henrietta Norton, Same address.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Pulmonary edema and congestion</b> DUE TO Conditions, if any, which gave rise to immediate cause (b) <b>Septicemia and pyelonephritis</b> (c) <b>Multiple infected ulcers of back, a Fracture of femur.</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>904.0</b>							
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>Fall in home.</b>					
20c. TIME OF INJURY Month, Day, Year Hour <b>3.30</b> P. M. <b>12-23-19 56</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Home</b>		20f. (City or town) (County) (State) <b>Riverdale, Pr. Geo. Md.</b>	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <b>John J. Maloney</b> M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <b>John T. Maloney, M.D.</b>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> <b>March 4, 1956</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>3-7-56</b>		22c. NAME OF CEMETERY OR CREMATORY <b>St. Mary's</b>		22d. LOCATION (City, town, or county) (State) <b>Riverdale, Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Amelia Norton</b>				24a. REC'D BY REGISTRAR <b>3/4/56</b>		24b. REGISTRAR'S SIGNATURE <b>Amelia Norton</b>	

University of Toronto - 3831 - Dr. H. W.  
Box 8-7 - Dr. H. W.

MAR 6 1956

BUREAU V. S.

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

03201

3195

## CERTIFICATE OF DEATH

Reg. Dist. No. 221

1. PLACE OF DEATH a. COUNTY <i>Prince Georges</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Maryland</i> b. COUNTY <i>Prince Georges</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>38 Cheverly</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Acceek</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>77 Prince Georges General Hospital</i>		d. STREET ADDRESS <i>Calvert Manor</i>	
3. NAME OF DECEASED (Type or print) First <i>Daisy</i> Middle <i>M.</i> Last <i>Popkins</i>		4. DATE OF DEATH Month <i>3</i> Day <i>24</i> Year <i>1956</i>	
5. SEX <i>Female</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>5-18-1873</i>
9. AGE (In years last birthday) <i>82</i> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) <i>Maryland</i>
12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>		13. FATHER'S NAME <i>George W. McIntosh</i>	
14. MOTHER'S MAIDEN NAME <i>Mary E. Mossburg</i>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <i>no</i> (If yes, give war or dates of service)	
16. SOCIAL SECURITY NO. <i>none</i>		17. INFORMANT <i>Statistic Card</i> Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>442X</i> DUE TO <i>Uremia</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Renal failure</i> DUE TO (c) <i>Arteriosclerotic Cardiovascular renal disease Unknown</i>			INTERVAL BETWEEN ONSET AND DEATH <i>4 days</i> <i>5 days</i>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <i>19</i>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <i>3-16</i> , 19 <i>56</i> , to <i>3-24</i> , 19 <i>56</i> , that I last saw the deceased alive on <i>3/24</i> , 19 <i>56</i> , and that death occurred at <i>10:09</i> P.M., from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>Julius J. Hoffman</i>		ADDRESS (Street, city or town, state) <i>5102 Annap. Rd. Bladensburg, Md</i>	
PHYSICIAN'S NAME (Type)		DATE SIGNED <i>3/24/56</i>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>	22b. DATE THEREOF <i>3-28-56</i>	22c. NAME OF CEMETERY OR CREMATORY <i>Congressional</i>	22d. LOCATION (City, town, or county) (State) <i>Washington, D.C.</i>
23. FUNERAL DIRECTOR'S SIGNATURE <i>W. W. Chambers Co.</i>		ADDRESS <i>Washington, D.C.</i>	
24a. REC'D BY REGISTRAR <i>3/26/56</i>		24b. REGISTRAR'S SIGNATURE <i>Abraham S. Downey</i>	

BUREAU V. S.

MAR 28 1956

RECEIVED

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained in your files.  
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the Registrar prior to burial, cremation, or removal.

BALTIMORE STATE DEPARTMENT OF HEALTH—BALTIMORE, 18										04361	
MEDICAL EXAMINER'S CERTIFICATE OF DEATH										Reg. Dist. No. 242	
1. PLACE OF DEATH a. COUNTY Prince George MARYLAND					2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE Maryland b. COUNTY Prince George						
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Oxen Hill			c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Oxen Hill						
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 6400 Tucker Rd.					d. STREET ADDRESS 6400 Tucker Rd.			e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) JAMES First EDWARD Middle PUMPHREY Last					4. DATE OF DEATH March 30 Day 19 56 Year						
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 5 Nov. 1908		9. AGE (In years last birthday) 47 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Plumber			10b. KIND OF BUSINESS OR INDUSTRY Naval Res. Lab.			11. BIRTHPLACE (State or foreign country) Md.			12. CITIZEN OF WHAT COUNTRY? U. S. A.		
13. FATHER'S NAME William T. Pumphrey					14. MOTHER'S MAIDEN NAME Mary E. Lanham						
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes			16. SOCIAL SECURITY NO. Unk.		17. INFORMANT Mabel C. Thorne 6320 St. Barnabas Rd., S. E. Address						
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hemorrhage and shock 976X DUE TO Conditions, if any, which gave rise to immediate cause (b) Gun shot wound of chest (a), stating the underlying cause lost. DUE TO (c)										INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)											
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Shot in chest with a shot gun								
20c. TIME OF INJURY Month, Day, Year Hour p. m. 3-30 1957			20d. INJURY OCCURRED White of work <input type="checkbox"/> Not white of work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Home		20f. (City or town) (County) (State) Oxen Hill P.S. Md.				
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input checked="" type="checkbox"/>											
ACTUAL SIGNATURE James I. Boyd					M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>			DATE SIGNED March 31, 1956			
EXAMINER'S NAME (Type) JAMES I. BOYD					ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial April 3-56			22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY St Barnabas			22d. LOCATION (City, town, or county) (State) Oxen Hill Md			
23. FUNERAL DIRECTOR'S SIGNATURE Simmons Bros. 1661-9th Hager					ADDRESS		24a. REC'D BY REGISTRAR DATE April 2-56		24b. REGISTRAR'S SIGNATURE Edna F. Gillio		



# MASSACHUSETTS DEPARTMENT OF HEALTH - BOSTON MEDICAL EXAMINER'S CERTIFICATE OF DEATH

BUREAU V. S.

APR 6 1956

RECEIVED



## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

234

3242

1. PLACE OF DEATH a. COUNTY <b>Prince George's</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Charles</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Accokeek</b>				c. LENGTH OF STAY IN lb			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Indian Head Highway</b>				d. STREET ADDRESS <b>Glymount Road</b>			
3. NAME OF DECEASED (Type or print) First <b>James</b> Middle <b>Edward</b> Last <b>Queen</b>				4. DATE OF DEATH Month <b>March</b> Day <b>3</b> Year <b>1956</b>			
5. SEX <b>Male</b>	6. COLOR OR RACE <b>Colored</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>July 11, 1937</b>		9. AGE (In years last birthday) <b>18 yrs.</b>	IF UNDER 1 YEAR Months <b>18</b> Days <b>08</b>	IF UNDER 24 HRS. Hours <b>08</b> Min. <b>2</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Laborer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>General</b>		11. BIRTHPLACE (State or foreign country) <b>Virginia</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
13. FATHER'S NAME <b>Thomas C. Queen</b>				14. MOTHER'S MAIDEN NAME <b>Mary E. Allen</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>Unknown</b>		17. INFORMANT <b>Thomas C. Queen, same as number 2</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Hemorrhage and shock</b> DUE TO Conditions, if any, which gave rise to immediate cause (b) <b>Fracture of the base of the skull</b> (c) <b>Crushed chest</b> DUE TO cause lost.							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>a fixed object</b>					
20c. TIME OF INJURY Month, Day, Year <b>4:00 p.m. 3/3/ 1956</b>		20d. INJURY OCCURRED While at work <input checked="" type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Scene of death</b>		20f. (City or town) (County) (State) <b>Accokeek P. G. Md.</b>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>				22b. DATE THEREOF <b>3-6-56</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Queens Cemetery</b>	
22d. LOCATION (City, town, or county) (State) <b>Hyattsville Md.</b>				22e. REC'D BY REGISTRAR <b>Mar 6, 1956</b>		22f. REGISTRAR'S SIGNATURE <b>Carrie Campbell</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>F. Baschi Bone Hyattsville, Md</b>							

ACTUAL SIGNATURE

EXAMINER'S NAME (Type)

James I. Boyd

M.D.

CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☐DEPUTY MEDICAL EXAMINER ☒

DATE SIGNED

March 3, 1956

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing "pending," in pencil in Item 18. Give Pages 1, 2, and 3 to the Registrar. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained in your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the Registrar prior to burial, cremation, or removal.

BUREAU V. S.

MAR 6 1956

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. To FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## CERTIFICATE OF DEATH

Reg. Dist. No.

03203  
237

3196

1. PLACE OF DEATH a. COUNTY <u>Prince Georges</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Prince Georges</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>38 Chesley, Md.</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>34 Brentwood</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>77 Prince Georges Gen. Hosp.</u>		d. STREET ADDRESS <u>4319 - 40<sup>th</sup> Place</u>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>Charles</u> First <u>HARRY</u> Middle <u>Reed</u> Last		4. DATE OF DEATH <u>March</u> Month <u>24</u> Day <u>19</u> Year <u>56</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>5/9/83</u>
9. AGE (In years last birthday) <u>72</u> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>GUARD</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>MD ELECTRONIC CORP.</u>	
11. BIRTHPLACE (State or foreign country) <u>WESTMORELAND CO., VA.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>CHARLES H. REED</u>		14. MOTHER'S MAIDEN NAME <u>FLORENCE BAKER</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes, give year or dates of service) <u>NONE</u>		16. SOCIAL SECURITY NO. <u>UNKNOWN</u>	
17. INFORMANT <u>ROSA B. REED</u> Address <u>4319 - 40<sup>th</sup> N. BRENTWOOD MD</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>332X Cerebral Thrombosis</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Generalized Arteriosclerosis</u> DUE TO (c) <u></u>		INTERVAL BETWEEN ONSET AND DEATH <u>2 weeks</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u></u>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>11 Mar, 1956</u> to <u>24 Mar, 1956</u> that I last saw the deceased alive on <u>23 Mar, 1956</u> and that death occurred at <u>6<sup>45</sup> AM</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Thomas G. Maloney</u> M.D. <u>4814-71st Ave</u>		DATE SIGNED <u>24 Mar 56</u>	
PHYSICIAN'S NAME (Type) <u>THOMAS G. MALONEY</u>		<u>LANDOVER HILLS MD</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>3/26/1956</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>FORT LINCOLN CEM.</u>		22d. LOCATION (City, town, or county) (State) <u>POLMAR MARSH PR GEO CO., MD</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>W.W. Chamberlaine</u> ADDRESS <u>Greenbelt, Md.</u>		24a. REC'D BY REGISTRAR <u>3/26/56</u>	
		24b. REGISTRAR'S SIGNATURE <u>Umanda Lounney</u>	

MAR 28 1956

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 7, Film G191, 3-27-56 et

3197

CERTIFICATE OF DEATH

03204

Reg. Dist. No.

231

1. PLACE OF DEATH a. COUNTY <u>Prince George's</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>Pr. George's</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>38 Chesley</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cedar Hts.</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>77 Prince George's Gen. Hosp</u>				d. STREET ADDRESS <u>6419-H St.</u>			
3. NAME OF DECEASED (Type or print) <u>Willie Ross</u> Middle Last				4. DATE OF DEATH Month <u>MAR.</u> Day <u>15</u> Year <u>1956</u>			
5. SEX <u>M</u>	6. COLOR OR RACE <u>C</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>1-1-1899</u>		9. AGE (In years last birthday) <u>57</u> yrs.	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Labour</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Contractor</u>		11. BIRTHPLACE (State or foreign country) <u>Keene Va</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>	
13. FATHER'S NAME <u>Fred Ross</u>				14. MOTHER'S MAIDEN NAME <u>Moyelle Robinson</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. (If yes, give war or dates of service)		17. INFORMANT Address <u>Hospital</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>445X Malignant Hypertension</u> DUE TO (b) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) _____ DUE TO _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)				20g. (City or town) (County) (State)			
21. I certify that I attended the deceased from <u>Jan. 1, 1956</u> to <u>3/15</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>3/15/56</u> , 19 <u>56</u> , and that death occurred at _____ M, from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Julius J. Griffin</u> M.D.				ADDRESS (Street, city or town, state) <u>5102 Annapolis Rd. Bladensburg, Md.</u>			
DATE SIGNED <u>3/15/56</u>							
PHYSICIAN'S NAME (Type) _____							
22a. (BURIAL) CREMATION, REMOVAL (Specify) <u>3-17-56</u>		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State) <u>Charlottesville Va</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>H. S. Washmon</u> ADDRESS <u>467 N of 7th</u>				24a. REC'D BY REGISTRAR DATE <u>3/19/56</u>		24b. REGISTRAR'S SIGNATURE <u>Amanda J. Jolley</u>	



# CERTIFICATE OF DEATH

and Date

1. NAME OF DECEASED		2. SEX		3. AGE		4. DATE OF BIRTH		5. PLACE OF BIRTH	
6. OCCUPATION		7. MARITAL STATUS		8. CAUSE OF DEATH		9. MANNER OF DEATH		10. PLACE OF DEATH	
11. SIGNATURE OF DECEASED		12. SIGNATURE OF WITNESSES		13. SIGNATURE OF PHYSICIAN		14. SIGNATURE OF CORONER		15. SIGNATURE OF JUDGE	
16. SIGNATURE OF CLERK		17. SIGNATURE OF REGISTRAR		18. SIGNATURE OF SHERIFF		19. SIGNATURE OF SHERIFF'S DEPUTY		20. SIGNATURE OF SHERIFF'S CLERK	
21. SIGNATURE OF SHERIFF'S CLERK		22. SIGNATURE OF SHERIFF'S CLERK		23. SIGNATURE OF SHERIFF'S CLERK		24. SIGNATURE OF SHERIFF'S CLERK		25. SIGNATURE OF SHERIFF'S CLERK	
26. SIGNATURE OF SHERIFF'S CLERK		27. SIGNATURE OF SHERIFF'S CLERK		28. SIGNATURE OF SHERIFF'S CLERK		29. SIGNATURE OF SHERIFF'S CLERK		30. SIGNATURE OF SHERIFF'S CLERK	
31. SIGNATURE OF SHERIFF'S CLERK		32. SIGNATURE OF SHERIFF'S CLERK		33. SIGNATURE OF SHERIFF'S CLERK		34. SIGNATURE OF SHERIFF'S CLERK		35. SIGNATURE OF SHERIFF'S CLERK	
36. SIGNATURE OF SHERIFF'S CLERK		37. SIGNATURE OF SHERIFF'S CLERK		38. SIGNATURE OF SHERIFF'S CLERK		39. SIGNATURE OF SHERIFF'S CLERK		40. SIGNATURE OF SHERIFF'S CLERK	
41. SIGNATURE OF SHERIFF'S CLERK		42. SIGNATURE OF SHERIFF'S CLERK		43. SIGNATURE OF SHERIFF'S CLERK		44. SIGNATURE OF SHERIFF'S CLERK		45. SIGNATURE OF SHERIFF'S CLERK	
46. SIGNATURE OF SHERIFF'S CLERK		47. SIGNATURE OF SHERIFF'S CLERK		48. SIGNATURE OF SHERIFF'S CLERK		49. SIGNATURE OF SHERIFF'S CLERK		50. SIGNATURE OF SHERIFF'S CLERK	
51. SIGNATURE OF SHERIFF'S CLERK		52. SIGNATURE OF SHERIFF'S CLERK		53. SIGNATURE OF SHERIFF'S CLERK		54. SIGNATURE OF SHERIFF'S CLERK		55. SIGNATURE OF SHERIFF'S CLERK	
56. SIGNATURE OF SHERIFF'S CLERK		57. SIGNATURE OF SHERIFF'S CLERK		58. SIGNATURE OF SHERIFF'S CLERK		59. SIGNATURE OF SHERIFF'S CLERK		60. SIGNATURE OF SHERIFF'S CLERK	
61. SIGNATURE OF SHERIFF'S CLERK		62. SIGNATURE OF SHERIFF'S CLERK		63. SIGNATURE OF SHERIFF'S CLERK		64. SIGNATURE OF SHERIFF'S CLERK		65. SIGNATURE OF SHERIFF'S CLERK	
66. SIGNATURE OF SHERIFF'S CLERK		67. SIGNATURE OF SHERIFF'S CLERK		68. SIGNATURE OF SHERIFF'S CLERK		69. SIGNATURE OF SHERIFF'S CLERK		70. SIGNATURE OF SHERIFF'S CLERK	
71. SIGNATURE OF SHERIFF'S CLERK		72. SIGNATURE OF SHERIFF'S CLERK		73. SIGNATURE OF SHERIFF'S CLERK		74. SIGNATURE OF SHERIFF'S CLERK		75. SIGNATURE OF SHERIFF'S CLERK	
76. SIGNATURE OF SHERIFF'S CLERK		77. SIGNATURE OF SHERIFF'S CLERK		78. SIGNATURE OF SHERIFF'S CLERK		79. SIGNATURE OF SHERIFF'S CLERK		80. SIGNATURE OF SHERIFF'S CLERK	
81. SIGNATURE OF SHERIFF'S CLERK		82. SIGNATURE OF SHERIFF'S CLERK		83. SIGNATURE OF SHERIFF'S CLERK		84. SIGNATURE OF SHERIFF'S CLERK		85. SIGNATURE OF SHERIFF'S CLERK	
86. SIGNATURE OF SHERIFF'S CLERK		87. SIGNATURE OF SHERIFF'S CLERK		88. SIGNATURE OF SHERIFF'S CLERK		89. SIGNATURE OF SHERIFF'S CLERK		90. SIGNATURE OF SHERIFF'S CLERK	
91. SIGNATURE OF SHERIFF'S CLERK		92. SIGNATURE OF SHERIFF'S CLERK		93. SIGNATURE OF SHERIFF'S CLERK		94. SIGNATURE OF SHERIFF'S CLERK		95. SIGNATURE OF SHERIFF'S CLERK	
96. SIGNATURE OF SHERIFF'S CLERK		97. SIGNATURE OF SHERIFF'S CLERK		98. SIGNATURE OF SHERIFF'S CLERK		99. SIGNATURE OF SHERIFF'S CLERK		100. SIGNATURE OF SHERIFF'S CLERK	

**RECEIVED**  
MAR 21 1956  
BUREAU V. S.



1

INSTRUCTIONS

**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

## MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

03205

3243

## CERTIFICATE OF DEATH

Reg. Dist. No. 242

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY Prince Georges		MARYLAND		STATE Maryland		COUNTY Prince Georges	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
TOWN Forest Heights		10 yrs.		TOWN Forest Heights			
HOSPITAL OR INSTITUTION OR STREET ADDRESS 210--Arapahoe Dr.				STREET ADDRESS (If rural give location) 210--Arapahoe Dr.			
3. NAME OF DECEASED (First) (Middle) (Last)				4. DATE OF DEATH (Month) (Day) (Year)			
LUCILLE ANN RUEFLY				March 26th 1956			
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	IF UNDER 1 YEAR		IF UNDER 24 HRS.
Female	White	Married	Sept. 5th, 1879	76 yrs.	Months	Days	Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
Housewife				Virginia		USA	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
Walter W. Hawkins				Mary A Dison			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS			
(If Yes, give war or dates of service)				Oren E. Ruefly-Son 210-Arapahoe Dr., Forest Hgts, Md.			
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
420.1 IMMEDIATE CAUSE (A) Coronary thrombosis							
ANTECEDENT CAUSE(S) DUE TO							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE							
STATING UNDERLYING CAUSE LAST. DUE TO							
(C)							
11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> M. at work <input type="checkbox"/> at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from Feb. 19 55, to March 26, 19 56, that I last saw the deceased alive on March 26, 19 56, and that death occurred at 7:57 P.M. from the causes and on the date stated above.							
SIGNATURE Dr. Etienne Gellera				ADDRESS (Street, city, town, state) DATE SIGNED			
M.D. 2. Parkway Dr.				Forest Hgts Md. 3/26/56			
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
Burial		Mar. 29-56		Cedar Hill Cemetery		Suitland, Maryland	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE		25. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS	
DATE Mar 27 56		Edna F. Sollum		Seminus Bros		1861--Good Hope Rd. SE. Washington, DC	

# 3548 CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE 12

1956

1. PLACE OF DEATH

2. NAME OF DECEASED

3. SEX

4. AGE

5. DATE OF BIRTH

6. PLACE OF BIRTH

7. OCCUPATION

8. CAUSE OF DEATH

9. MANNER OF DEATH

10. SIGNATURE OF PHYSICIAN

11. SIGNATURE OF REGISTRAR

12. SIGNATURE OF WITNESSES

13. SIGNATURE OF DECEASED

14. SIGNATURE OF NEXT OF KIN

15. SIGNATURE OF BURIAL OFFICIAL

16. SIGNATURE OF CHURCH OFFICIAL

17. SIGNATURE OF FUNERAL HOME

18. SIGNATURE OF CEMETERY

19. SIGNATURE OF INTERVIEWER

20. SIGNATURE OF CLERK

21. SIGNATURE OF ASSISTANT CLERK

22. SIGNATURE OF RECEPTIONIST

23. SIGNATURE OF TELEPHONE OPERATOR

24. SIGNATURE OF MAIL ROOM

25. SIGNATURE OF RECORDS SECTION

26. SIGNATURE OF STATISTICS SECTION

27. SIGNATURE OF LABORATORY

28. SIGNATURE OF X-RAY DEPARTMENT

29. SIGNATURE OF PATHOLOGY DEPARTMENT

BUREAU V. S.

APR 3 1956

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 3244 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

03206

Reg. Dist. No. 242

<b>1. PLACE OF DEATH</b> a. COUNTY <u>Prince Georges</u> MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Fort Foote Village</u> c. LENGTH OF STAY IN 1b <u>2 1/2 yrs</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>007203 Sentry Lane SE</u>				<b>2. USUAL RESIDENCE</b> (Where deceased lived. If Institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Prince Georges</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Fort Foote Village</u> d. STREET ADDRESS <u>7203 Sentry Lane SE</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
<b>3. NAME OF DECEASED</b> (Type or print) <u>Wongler Ingham Sandborn</u> 5. SEX <u>male</u> 6. COLOR OR RACE <u>white</u> 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> 8. DATE OF BIRTH <u>July 4, 1910</u> 9. AGE (In years last birthday) <u>45</u> yrs. IF UNDER 1 YEAR: Months <u>  </u> Days <u>  </u> IF UNDER 24 HRS.: Hours <u>  </u> Min. <u>  </u>				<b>4. DATE OF DEATH</b> <u>March 22</u> 19 <u>56</u> <b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>Nursing</u> <b>10b. KIND OF BUSINESS OR INDUSTRY</b> <u>St. Elizabeth Hosp. Michigan</u> <b>11. BIRTHPLACE</b> (State or foreign country) <u>U. S. A</u> <b>12. CITIZEN OF WHAT COUNTRY?</b> <u>U. S. A</u>			
<b>13. FATHER'S NAME</b> <u>Charter Sandborn</u> <b>14. MOTHER'S MAIDEN NAME</b> <u>Thara Mills</u>				<b>15. WAS DECEASED EVER IN U. S. ARMED FORCES?</b> (Yes, no, or unknown) <u>no</u> (If yes, give war or dates of service) <b>16. SOCIAL SECURITY NO.</b> <u>none</u> <b>17. INFORMANT</b> <u>Betty Sandborn</u> Address <u>same address</u>			
<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute congestive heart failure</u> <u>420.1</u> DUE TO (b) <u>Coronary Occlusion</u> Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause last. DUE TO <u>Cardiosclerotic renal disease</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>  </u> INTERVAL BETWEEN ONSET AND DEATH <u>  </u>							
<b>20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.</b> <b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.) <u>  </u>				<b>19. WAS AUTOPSY PERFORMED?</b> YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
<b>20c. TIME OF INJURY</b> Month, Day, Year Hour a. m. p. m. <u>  </u> 19 <u>  </u>		<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.) <u>  </u>		<b>20f. (City or town)</b> (County) (State) <u>  </u>	
<b>21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/>, Inspection <input checked="" type="checkbox"/>, Inquiry <input type="checkbox"/>, and find that death resulted from:</b> Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
<b>ACTUAL SIGNATURE</b> <u>James I. Boyd</u> M.D. <b>EXAMINER'S NAME (Type)</b> <u>James I. Boyd</u>				<b>CHIEF MEDICAL EXAMINER</b> <input type="checkbox"/> <b>ASSISTANT MEDICAL EXAMINER</b> <input type="checkbox"/> <b>DEPUTY MEDICAL EXAMINER</b> <input checked="" type="checkbox"/>			
<b>22a. BURIAL, CREMATION, REMOVAL (Specify)</b> <u>Burial</u>		<b>22b. DATE THEREOF</b> <u>Mar. 25-56</u>		<b>22c. NAME OF CEMETERY OR CREMATORY</b> <u>St. Elizabeth Cemetery</u>		<b>22d. LOCATION (City, town, or county)</b> (State) <u>Parkersburg West Va.</u>	
<b>23. FUNERAL DIRECTOR'S SIGNATURE</b> <u>Summers Bros.</u> ADDRESS <u>1661- 20th St NE Wash. D.C.</u>				<b>24a. REC'D BY REGISTRAR</b> <u>Mar 26-56</u>		<b>24b. REGISTRAR'S SIGNATURE</b> <u>Edw. F. Collins</u>	

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation or removal.

MISSOURI STATE DEPARTMENT OF HEALTH - BUREAU OF VITALS  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

NAME		AGE		SEX		RACE		RELIGION		MARRIAGE		EDUCATION		OCCUPATION		RESIDENCE		DATE OF DEATH		PLACE OF DEATH		CAUSE OF DEATH		MANNER OF DEATH		SIGNATURE		DATE	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)  
15M 9/55

Item 9, Film G194 3-15-56 et  
3198  
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
CERTIFICATE OF DEATH

03207

Reg. Dist. No. 231

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE --- b. COUNTY ---	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 38 Cheverly		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington, D.C.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 77 Prince Georges Co. General Hosp		d. STREET ADDRESS 1504 18th. Street, S.E.	
3. NAME OF DECEASED (Type or print) First MIDDLE Last GUY H SHAWEN		4. DATE OF DEATH Month March Day 8 Year 19 56	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Month 11, 1889 66 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) CLERK - Liquor		10b. KIND OF BUSINESS OR INDUSTRY Greer Co. Retail	
11. BIRTHPLACE (State or foreign country) Waterford, Va.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Charles Shawen		14. MOTHER'S MAIDEN NAME Rosalie Russell	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 578-10-0190	
17. INFORMANT Mrs. Helen Forbes		Address 1504 18th. St., SE DC20	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 332X Brouchopneumonia DUE TO (b) Cerebral Vascular Sclerosis DUE TO (c) Cerebral Thrombosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		INTERVAL BETWEEN ONSET AND DEATH 48 hrs 4 yrs 10 days	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from June, 1950, to March, 1956, that I last saw the deceased alive on March 7, 1956, and that death occurred at 12:50 AM, from the causes and on the date stated above.			
ACTUAL SIGNATURE Benjamin S. Miller		ADDRESS (Street, city or town, state) 3824-34 St Mt. Rainier Md	
DATE SIGNED 3/8/56			
PHYSICIAN'S NAME (Type) BENJAMIN S. MILLER		3824 34 St. Mt. Rainier, MD	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 3/10/1956	
22c. NAME OF CEMETERY OR CREMATORY Flint Hill Cemetery		22d. LOCATION (City, town, or county) (State) Oakton, Fairfax Co., Virginia	
23. FUNERAL DIRECTOR'S SIGNATURE James T. Ryan, Jr.		ADDRESS Wash. 3, D.C. 317 Penna. Ave., S.E.	
24a. REC'D BY REGISTRAR DATE 12 1956		24b. REGISTRAR'S SIGNATURE Amanda Brown	







TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it shall be filed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)  
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3199

CERTIFICATE OF DEATH

04369

Reg. Dist. No.

231

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE b. COUNTY Prince Georges	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 38 77 Chesley		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 38 Chesley	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Prince Georges Hosp.		d. STREET ADDRESS 6007 Kilmer St.	
3. NAME OF DECEASED (Type or print) Henry First MIDDLE Last FREDRICK S. MON		4. DATE OF DEATH Month 3 Day 31 Year 1956	
5. SEX M	6. COLOR OR RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH OCT 25, 1904 57 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) D.C. GOV'T		11. BIRTHPLACE (State or foreign country) D.C.	
13. FATHER'S NAME CHRISTOPH SIMON		14. MOTHER'S MAIDEN NAME ALMA GROLL	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO. 17. INFORMANT Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.1 Sudden Coronary Occlusion DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerotic Coronary disease DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH 15 mi		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Oct 1, 1955, to 3-31, 1956, that I last saw the deceased alive on 3-31-1956, and that death occurred at 1:30 p. m. from the causes and on the date stated above.			
ACTUAL SIGNATURE George J. Hagenge		ADDRESS (Street, city or town, state) DATE SIGNED 3-31-56	
PHYSICIAN'S NAME (Type)			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 4-4-56	
22c. NAME OF CEMETERY OR CREMATORY Cedar Hill		22d. LOCATION (City, town, or county) (State) Suitland, Md	
23. FUNERAL DIRECTOR'S SIGNATURE J. W. M. Lee		24a. REC'D BY REGISTRAR 24b. REGISTRAR'S SIGNATURE	
ADDRESS Somo Co - Wash, DC		DATE 4/5/56	

CERTIFICATE OF DEATH

1. NAME OF DECEASED		2. SEX		3. AGE	
4. RACE		5. BIRTH DATE		6. BIRTH PLACE	
7. MARRIED		8. OCCUPATION		9. CAUSE OF DEATH	
10. PLACE OF DEATH		11. TIME OF DEATH		12. SIGNATURE OF PHYSICIAN	
13. SIGNATURE OF REGISTRAR		14. SIGNATURE OF WITNESS		15. SIGNATURE OF DECEASED	
16. SIGNATURE OF DECEASED		17. SIGNATURE OF DECEASED		18. SIGNATURE OF DECEASED	
19. SIGNATURE OF DECEASED		20. SIGNATURE OF DECEASED		21. SIGNATURE OF DECEASED	
22. SIGNATURE OF DECEASED		23. SIGNATURE OF DECEASED		24. SIGNATURE OF DECEASED	
25. SIGNATURE OF DECEASED		26. SIGNATURE OF DECEASED		27. SIGNATURE OF DECEASED	
28. SIGNATURE OF DECEASED		29. SIGNATURE OF DECEASED		30. SIGNATURE OF DECEASED	
31. SIGNATURE OF DECEASED		32. SIGNATURE OF DECEASED		33. SIGNATURE OF DECEASED	
34. SIGNATURE OF DECEASED		35. SIGNATURE OF DECEASED		36. SIGNATURE OF DECEASED	
37. SIGNATURE OF DECEASED		38. SIGNATURE OF DECEASED		39. SIGNATURE OF DECEASED	
40. SIGNATURE OF DECEASED		41. SIGNATURE OF DECEASED		42. SIGNATURE OF DECEASED	
43. SIGNATURE OF DECEASED		44. SIGNATURE OF DECEASED		45. SIGNATURE OF DECEASED	
46. SIGNATURE OF DECEASED		47. SIGNATURE OF DECEASED		48. SIGNATURE OF DECEASED	
49. SIGNATURE OF DECEASED		50. SIGNATURE OF DECEASED		51. SIGNATURE OF DECEASED	
52. SIGNATURE OF DECEASED		53. SIGNATURE OF DECEASED		54. SIGNATURE OF DECEASED	
55. SIGNATURE OF DECEASED		56. SIGNATURE OF DECEASED		57. SIGNATURE OF DECEASED	
58. SIGNATURE OF DECEASED		59. SIGNATURE OF DECEASED		60. SIGNATURE OF DECEASED	
61. SIGNATURE OF DECEASED		62. SIGNATURE OF DECEASED		63. SIGNATURE OF DECEASED	
64. SIGNATURE OF DECEASED		65. SIGNATURE OF DECEASED		66. SIGNATURE OF DECEASED	
67. SIGNATURE OF DECEASED		68. SIGNATURE OF DECEASED		69. SIGNATURE OF DECEASED	
70. SIGNATURE OF DECEASED		71. SIGNATURE OF DECEASED		72. SIGNATURE OF DECEASED	
73. SIGNATURE OF DECEASED		74. SIGNATURE OF DECEASED		75. SIGNATURE OF DECEASED	
76. SIGNATURE OF DECEASED		77. SIGNATURE OF DECEASED		78. SIGNATURE OF DECEASED	
79. SIGNATURE OF DECEASED		80. SIGNATURE OF DECEASED		81. SIGNATURE OF DECEASED	
82. SIGNATURE OF DECEASED		83. SIGNATURE OF DECEASED		84. SIGNATURE OF DECEASED	
85. SIGNATURE OF DECEASED		86. SIGNATURE OF DECEASED		87. SIGNATURE OF DECEASED	
88. SIGNATURE OF DECEASED		89. SIGNATURE OF DECEASED		90. SIGNATURE OF DECEASED	
91. SIGNATURE OF DECEASED		92. SIGNATURE OF DECEASED		93. SIGNATURE OF DECEASED	
94. SIGNATURE OF DECEASED		95. SIGNATURE OF DECEASED		96. SIGNATURE OF DECEASED	
97. SIGNATURE OF DECEASED		98. SIGNATURE OF DECEASED		99. SIGNATURE OF DECEASED	
100. SIGNATURE OF DECEASED		101. SIGNATURE OF DECEASED		102. SIGNATURE OF DECEASED	

BUREAU V. S.

APR 9 1956

RECEIVED

## 3200 CERTIFICATE OF DEATH

Reg. Dist. No. 231

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY <u>Prince Georges</u> MARYLAND	CITY (If outside corporate limits, write RURAL and give nearest town) <u>Bladensburg</u> OR TOWN <u>40 yrs</u>	STATE <u>Maryland</u> COUNTY <u>Ptse</u>	CITY (If outside corporate limits, write RURAL and give nearest town) <u>Bladensburg</u> OR TOWN <u>33</u>
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Capitol View</u>		STREET ADDRESS (If rural give location) <u>Capitol View</u>	
3. NAME OF DECEASED: (Type or Print) (First) (Middle) (Last) <u>LEWIS ARTHUR SMALLWOOD</u>		4. DATE OF DEATH: (Month) (Day) (Year) <u>3-1-56</u>	
5. SEX: <u>M.</u>	6. COLOR OR RACE: <u>C</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>WIDOW</u>	8. DATE OF BIRTH: <u>7-4-1877</u>
9. AGE last birthday: <u>78</u> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION. Give kind of work done during most of working life, even if retired: <u>FARMER</u>		10b. KIND OF BUSINESS OR INDUSTRY: <u>FARM</u>	
11. BIRTHPLACE (State or foreign country): <u>ANNAPOLIS</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>	
13. FATHER'S NAME: <u>JOHN SMALLWOOD</u>		14. MOTHER'S MAIDEN NAME: <u>EVELYN STRIBBLING</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) <u>NO</u> (If Yes, give war or dates of service)		16. SOCIAL SECURITY No.: <u>—</u>	
17. INFORMANT & ADDRESS: <u>GEORGE A. SMALLWOOD</u>		<u>Bladens-very m</u>	
18. MEDICAL CERTIFICATION			
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			
727x Immediate cause		(a) <u>Hypertensive Pneumonia</u>	
Antecedent causes (s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last.		(b) <u>Hypertension</u>	
		(c) <u>Phlebotomy</u>	
Interval Between Onset And Death <u>1 wk</u>			
<u>Several yrs</u>			
<u>9-10 yrs.</u>			
11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <u>Prostatectomy</u>			
19a. DATE OF OPERATION: <u>1950</u>		19b. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? Yes <input type="checkbox"/> No <input type="checkbox"/>			
21. ACCIDENT SUICIDE HOMICIDE (Specify)		PLACE (Home, farm, factory, street, office bldg., etc.)	
TIME (Month) (Day) (Year) (Hour) OF INJURY		INJURY OCCURRED While at Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	
		HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <u>2-14-56</u> , 1956, to <u>3-1-56</u> , 1956, that I last saw the deceased alive on <u>2-15-56</u> , 1956, and that death occurred at <u>2:00 AM</u> , from the causes and on the date stated above.			
SIGNATURE <u>W. W. Spalley</u> (Degree or title)		ADDRESS <u>M. H. Brentwood Rd.</u> DATE SIGNED <u>3-1-56</u>	
23. BURIAL, CREMATION, REMOVAL (Specify)		DATE THEREOF <u>3/1/56</u>	
NAME OF CEMETERY OR CREMATORY <u>Washington D.C.</u>		LOCATION (City, town, or county) (State)	
DATE REC'D BY LOCAL REGISTRAR <u>3/1/56</u>		REGISTRAR'S SIGNATURE <u>Amanda Lawrence</u>	
24. FUNERAL DIRECTOR <u>East Williams</u>		ADDRESS <u>Wash. D.C.</u>	

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

MAR 5 1956

BUREAU V. S.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 3201 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

03209

Reg. Dist. No. 231

<b>1. PLACE OF DEATH</b> a. COUNTY <u>Prince Georges</u> MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cherley</u> c. LENGTH OF STAY IN 1b <u>Dead on arrival</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Prince Georges General Hospital</u>				<b>2. USUAL RESIDENCE</b> (Where deceased lived. If Institution, Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Prince Georges</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Upper Marlboro</u> d. STREET ADDRESS <u>Route 1 Box #5</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
<b>3. NAME OF DECEASED</b> (Type or print) <u>Henry Pope Smith</u>		<b>4. DATE OF DEATH</b> Month <u>March</u> Day <u>26</u> Year <u>1956</u>		<b>5. SEX</b> <u>Male</u>									
<b>6. COLOR OR RACE</b> <u>White</u>		<b>7. MARRIED</b> <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		<b>8. DATE OF BIRTH</b> <u>Nov 8, 1904</u>									
<b>9. AGE</b> (In years last birthday) <u>52</u> yrs. <table border="1" style="display: inline-table; width: 100px;"> <tr> <td colspan="2">IF UNDER 1 YEAR</td> <td colspan="2">IF UNDER 24 HRS.</td> </tr> <tr> <td>Months</td> <td>Days</td> <td>Hours</td> <td>Min.</td> </tr> </table>		IF UNDER 1 YEAR		IF UNDER 24 HRS.		Months	Days	Hours	Min.	<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>Construction Superintendent Building</u>		<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <u>Georgia</u>	
IF UNDER 1 YEAR		IF UNDER 24 HRS.											
Months	Days	Hours	Min.										
<b>11. BIRTHPLACE</b> (State or foreign country) <u>U.S.A.</u>				<b>12. CITIZEN OF WHAT COUNTRY?</b> <u>U.S.A.</u>									
<b>13. FATHER'S NAME</b> <u>Walter Bolton Smith</u>				<b>14. MOTHER'S MAIDEN NAME</b> <u>Elizabeth Casby</u>									
<b>15. WAS DECEASED EVER IN U. S. ARMED FORCES?</b> (Yes, no, or unknown) <u>no</u>		<b>16. SOCIAL SECURITY NO.</b> <u>578-03-6122</u>		<b>17. INFORMANT</b> <u>Carl E. Smith</u> Address <u>671 Nottsbene Drive Alexandria, VA</u>									
<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Hemorrhage and shock</u> DUE TO (b) <u>Crushed chest.</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____													
<b>19. WAS AUTOPSY PERFORMED?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>													
<b>20a. EXTERNAL CAUSE WAS PRIMARY OR CONTRIBUTING CAUSE OF DEATH.</b> <input type="checkbox"/>		<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.) <u>Caught under an overhanging tractor</u>											
<b>20c. TIME OF INJURY</b> Month, Day, Year <u>7:15 a.m. 3-26-1956</u>		<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.) <u>Home</u>									
<b>20f. (City or town)</b> <u>Upper Marlboro P. S.</u>		<b>20g. (County)</b> <u>Prince Georges</u>		<b>20h. (State)</b> <u>Md.</u>									
<b>21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from:</b> Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/>													
<b>ACTUAL SIGNATURE</b> <u>James I. Boyd</u>		<b>EXAMINER'S NAME (Type)</b> <u>JAMES I. BOYD</u>		<b>CHIEF MEDICAL EXAMINER</b> <input type="checkbox"/> <b>ASSISTANT MEDICAL EXAMINER</b> <input type="checkbox"/> <b>DEPUTY MEDICAL EXAMINER</b> <input checked="" type="checkbox"/>									
<b>22a. BURIAL, CREMATION, REMOVAL (Specify)</b> <u>Burial</u>		<b>22b. DATE THEREOF</b> <u>3/29/56</u>		<b>22c. NAME OF CEMETERY OR CREMATORY</b> <u>National Mem. Park Cem.</u>									
<b>22d. LOCATION</b> (City, town, or county) <u>Falls Church</u>		<b>22e. (State)</b> <u>Va.</u>		<b>23. FUNERAL DIRECTOR'S SIGNATURE</b> <u>Ritchie Bros. Upper Marlboro, Md.</u>									
<b>24a. REC'D BY REGISTRAR</b> <u>DATE 3/29/56</u>		<b>24b. REGISTRAR'S SIGNATURE</b> <u>Amanda Dourney</u>											

MEDICAL CERTIFICATION

16

2

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the General Director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

THE MEDICAL EXAMINER'S CERTIFICATE OF DEATH  
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE 18

BUREAU V. S.

APR 3 1956

RECEIVED



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After the death certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

3202

CERTIFICATE OF DEATH

03210

Reg. Dist. No. 251

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Prince Georges			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 38 Chedoke				c. LENGTH OF STAY IN 1b D.O.A.			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 99 Prince Geo. Gen Hosp				d. STREET ADDRESS 5825 Rollins Ave			
3. NAME OF DECEASED (Type or print) NEAL Sparks				4. DATE OF DEATH Month March Day 10 Year 1956			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 9 March 1909	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Craftsman		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Wyo.		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME ALPHONSE SPARKS				14. MOTHER'S MAIDEN NAME ALICE BAHEN			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) [If yes, give war or dates of service]				17. INFORMANT LEWIS SPARKS 836-6828 St. BKN. N.Y.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial infarction 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Coronary Occlusion with DUE TO (c) Infarction INTERVAL BETWEEN ONSET AND DEATH few minutes 2 yrs.							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from March 15, 1954 to March 10, 1956, that I last saw the deceased alive on Jan. 15, 1956, and that death occurred at 10:35 P.M. from the causes and on the date stated above.							
ACTUAL SIGNATURE William Brainin M.D.				ADDRESS (Street, city or town, state) 6124 Central Ave			
PHYSICIAN'S NAME (Type) WM BRAININ				DATE SIGNED 3/10/56			
22a. BURIAL, CREMATION, REMOVAL (Specify) Cremation		22b. DATE THEREOF 3-11-56		22c. NAME OF CEMETERY OR CREMATORY Lees Crematory		22d. LOCATION (City, town, or county) Washington D.C. (State)	
23. FUNERAL DIRECTOR'S SIGNATURE J.W. Lees Sons				ADDRESS Washington D.C.		24a. REC'D BY REGISTRAR DATE 3/13/56	
						24b. REGISTRAR'S SIGNATURE Amanda Dourney	

Coroner Maloney called & permission  
given to sign death certificate  
W. Brannin

BUREAU V. S.

MAR 15 1956

RECEIVED

W. Brannin  
3-11-56  
Kearney

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained in your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)  
5M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
3245 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

03212

Reg. Dist. No. 242

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE Maryland b. COUNTY Prince Georges	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Camp Springs		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Camp Springs	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 6402 Sumner		d. STREET ADDRESS 6402 Sumner Drive	
3. NAME OF DECEASED (Type or print) Hannah Joyner		4. DATE OF DEATH March 4 1956	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 74 yrs.
9. AGE (In years last birthday) 74 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) none		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Ireland		12. CITIZEN OF WHAT COUNTRY? United States	
13. FATHER'S NAME John Desmond		14. MOTHER'S MAIDEN NAME Margaret	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO.	
17. INFORMANT Henry Rickelsen		Address same address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 442X acute congestive heart failure DUE TO (b) Cardiovascular renal disease Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause last. DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> . Inspection <input checked="" type="checkbox"/> . Inquiry <input checked="" type="checkbox"/> . and find that death resulted from: Natural causes <input checked="" type="checkbox"/> . Accident <input type="checkbox"/> . Suicide <input type="checkbox"/> . Homicide <input type="checkbox"/> . Undetermined cause <input type="checkbox"/> .			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 2-7-56	
22c. NAME OF CEMETERY OR CREMATORY Mt. Olivet		22d. LOCATION (City, town, or county) (State) Wash. D.C.	
23. FUNERAL DIRECTOR'S SIGNATURE Timothy Hudson		24. REC'D BY REGISTRAR DATE Mar. 4-56	
25. REGISTRAR'S SIGNATURE		26. REGISTRAR'S SIGNATURE Edna F. Collins	

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 13  
 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

NAME OF DECEASED _____		SEX _____	
AGE _____		DATE OF BIRTH _____	
PLACE OF BIRTH _____		OCCUPATION _____	
CAUSE OF DEATH _____		MANNER OF DEATH _____	
SIGNATURE OF EXAMINER _____		DATE _____	

BUREAU V. S.

MAR 8 1956

RECEIVED

3-7-56  
 3-7-56  
 3-7-56

1  
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1  
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 12, Film G194 3-29-56 et

3203

CERTIFICATE OF DEATH

03213

Reg. Dist. No. 231

1. PLACE OF DEATH o. COUNTY Prince Georges MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Prince George	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 381 Cherry Road		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 34 - Brentwood	
d. NAME OF HOSPITAL (If not in hospital, give street address) 77 Prince Georges Gen. Hosp.		d. STREET ADDRESS 3735 Rhode Island	
3. NAME OF DECEASED (Type or print) Mary First Middle Last Triebler		4. DATE OF DEATH March 24, 1956	
5. SEX 7	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 8/15/81
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) 203X		9. AGE (In years last birthday) 74 yrs. IF UNDER 1 YEAR Months Days Hours Min. IF UNDER 24 HRS.	
10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Ireland	
13. FATHER'S NAME 7		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
14. MOTHER'S MAIDEN NAME 7		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No	
16. SOCIAL SECURITY NO. -		17. INFORMANT Hoppe Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 203X DUE TO Bronchopneumonia Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) multiple myeloma, generalized 1 year (c)		INTERVAL BETWEEN ONSET AND DEATH 2 weeks	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. ft. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Jan 1, 1955, to March 17, 1956, that I last saw the deceased alive on March 12, 1956, and that death occurred at 6:30 PM, from the causes and on the date stated above.			
ACTUAL SIGNATURE Samuel N. Sugar M.D.		ADDRESS (Street, city or town, state) DATE SIGNED	
PHYSICIAN'S NAME (Type) 4300 KAYWOOD Drive		Mt Rainier Md 1956	
22a. BURIAL, CREMATION, REMOVAL (Specify) 3-27-56		22b. DATE THEREOF	
22c. NAME OF CEMETERY OR CREMATORY Mt Olivet Cemetery		22d. LOCATION (City, town, or country) (State) Wash. DC	
23. FUNERAL DIRECTOR'S SIGNATURE Timothy Hauben		ADDRESS 3831- St An NW	
24a. REC'D BY REGISTRAR DATE 3/25/56		24b. REGISTRAR'S SIGNATURE Amanda L. Loring	



BUREAU V. S.

MAR 27 1955

RECEIVED



# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3246

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

03214

Item 2, Film 195 4-12-56 et

Reg. Dist. No. 232

1. PLACE OF DEATH a. COUNTY <u>Prince George's</u> <u>MARYLAND</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Pr. Geo's</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rosaryville</u>		c. LENGTH OF STAY IN 1b <u>Transient</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Route 301 1/2 mile South of Croome Rd.</u>		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Stevensville, Maryland</u>	
3. NAME OF DECEASED (Type or print) First <u>Emerson</u> Middle <u>Harrington</u> Last <u>Truitt</u>		4. DATE OF DEATH Month <u>March</u> Day <u>30</u> Year <u>19 56</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>March 1, 1933</u>
9. AGE (In years last birthday) <u>23</u> yrs.		IF UNDER 1 YEAR Months <u>23</u> Days <u>0</u> Hours <u>0</u> Min. <u>0</u>	IF UNDER 24 HRS. Hours <u>0</u> Min. <u>0</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Marine</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>U. S. Marines</u>	
11. BIRTHPLACE (State or foreign country) <u>District of Columbia</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>Reginald V. Truitt</u>		14. MOTHER'S MAIDEN NAME <u>Mary H. Harrington</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>Yes</u>		16. SOCIAL SECURITY NO. <u>Nov. 12, 1954</u>	
17. INFORMANT <u>Reginald V. Truitt</u>		Address <u>Stevensville, Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Hemorrhage and shock</u> DUE TO Conditions, if any, which gave rise to immediate cause (b) <u>Fracture and dislocation of the 1st to 3rd cervical vertebrae. Severance of the spinal cord</u> (c) <u>Fracture of the base of the skull, crushed chest</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Occupant of an automobile that was thrown from the/</u>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18) <u>automobile to ground</u>	
20c. TIME OF INJURY Month, Day, Year Hour <u>6:50</u> p. m. <u>3/30/56</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Rt # 301</u>	20f. (City or town) (County) (State) <u>Rosaryville P. G. Md.</u>
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <u>James I. Boyd</u>		DATE SIGNED <u>3/30/56</u>	
EXAMINER'S NAME (Type) <u>James I. Boyd</u>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>4/2/56</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Christ Church Cemetery</u>	22d. LOCATION (City, town, or county) (State) <u>Cambridge, Maryland</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Ritchie Brothers Funeral Home</u>		24. REGISTRAR'S SIGNATURE <u>John F. Danner</u>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

RECEIVED

BUREAU V. S.

APR 5 1996

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. This certificate has been signed by the attending physician and completed in by the funeral director, TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

03215

3204

## CERTIFICATE OF DEATH

Reg. Dist. No.

231

1. PLACE OF DEATH o. COUNTY <u>Prince George's</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Prince George's</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>28 Cheeverly</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Beltsville</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>PRINCE Geo-Gen Hosp</u>				d. STREET ADDRESS <u>11606-34th Pl -</u>			
3. NAME OF DECEASED (Type or print) First <u>Baby Boy</u> Middle <u>Walsh</u> Last <u>Walsh</u>				4. DATE OF DEATH Month <u>Mar</u> Day <u>22</u> Year <u>1956</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>22 Mar 56</u>	
9. AGE (In years last birthday) yrs.		IF UNDER 1 YEAR		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>John Gleason Walsh</u>				14. MOTHER'S MAIDEN NAME <u>Henriette Beatrice Boardse</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. (If yes, give war or dates of service)		17. INFORMANT <u>Stat. Card</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Fetal Atelectasis</u> <u>761.5</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Generalized edema (cause undetermined)</u> (c) <u>Premature rupture of membranes</u> (d) <u>Prematurity (2400 gms. 44 cm.)</u>						INTERVAL BETWEEN ONSET AND DEATH <u>Birth</u> <u>Birth</u> <u>1 month</u> <u>Birth</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. p. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)				20g. (County)		20h. (State)	
21. I certify that I attended the deceased from _____, 19____, to _____, 19____, that I last saw the deceased alive on _____, 19____, and that death occurred at _____ M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED							
ACTUAL SIGNATURE <u>Cornelius J. Burns</u> PHYSICIAN'S NAME (Type) <u>Cornelius J. Burns, M.D.</u>				M.D. <u>Prince Georges Gen. Hosp., Cheverly, Md.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>3/23/56</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Fort Lincoln Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Adman Manor Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Valley Funeral Home</u> ADDRESS <u>3288 R. 1 Ave</u> <u>mt Rainier, Md.</u>				24a. REC'D BY REGISTRAR <u>DATE 3/23/56</u>		24b. REGISTRAR'S SIGNATURE <u>Amanda Doney</u>	

2077735323

# CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE, 18

DATE OF DEATH

DEATH

MARITAL

PLACE OF DEATH

DEATH

U. S. DEPARTMENT OF HEALTH

BUREAU V. S.

MAR 27 1956

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. This certificate has been signed by the attending physician and completed in by the funeral director. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3205

CERTIFICATE OF DEATH

03216

Reg. Dist. No.

331

1. PLACE OF DEATH a. COUNTY <u>Prince Georges</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>47X-3</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Chesley, Md</u>		c. LENGTH OF STAY IN 1b <u>3 days</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Prince Georges Gen. Hosp</u>		d. STREET ADDRESS <u>6317 Ritchie Rd</u>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>Charles Howard Wendell</u>		4. DATE OF DEATH Month Day Year <u>MARCH 27 1956</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWER <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>UNKNOWN</u>
9. AGE (In years and birthday) <u>84 yrs.</u>		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>MERCHANT</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>GROCERY</u>	
11. BIRTHPLACE (State or foreign country) <u>WEST VIRGINIA</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>MARTIN WENDELL</u>		14. MOTHER'S MAIDEN NAME <u>UNKNOWN</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>No</u>	
17. INFORMANT <u>CHESTER H. WENDELL</u>		Address <u>6317 RICHIE RD DC.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>420.0</u> DUE TO <u>Bronchopneumonia, Terminal</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Congestive heart failure</u> (c) <u>Arteriosclerotic heart disease</u> INTERVAL BETWEEN ONSET AND DEATH <u>3 days</u> <u>Indist.</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>3/24/56</u> , 19 <u>56</u> , to <u>3/27</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>3/27/56</u> , 19 <u>56</u> , and that death occurred at <u>1:21 P.M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Julius Gauffman</u>		ADDRESS (Street, city or town, state) DATE SIGNED <u>5102 Annap. Rd. Bladensburg Md 3/27/56</u>	
PHYSICIAN'S NAME (Type)			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>3-31-56</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>W.W. Chamber Co. Wash. D.C.</u>		22d. LOCATION (City, town, or county) (State) <u>ROMNEY W. VA</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>W.W. Chamber Co. Wash. D.C.</u>		24a. REC'D BY REGISTRAR DATE <u>3/31/56</u>	
24b. REGISTRAR'S SIGNATURE <u>Amanda L. Lowney</u>			







## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

03217

## 3206 CERTIFICATE OF DEATH

Reg. Dist. No. 239

1. PLACE OF DEATH: COUNTY <u>Prince George</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED: STATE <u>Maryland</u> COUNTY <u>Pr. Geo.</u>	
CITY (If outside corporate limits, write RURAL and OR give nearest town) <u>Laurel</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Laurel</u>	
TOWN <u>Laurel</u>		TOWN <u>Laurel</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>501 Prince George St</u>		STREET ADDRESS (If rural, give location) <u>501 Prince George Street</u>	
3. NAME OF DECEASED (First) <u>Miriam</u> (Middle) <u>May</u> (Last) <u>White</u>		4. DATE OF DEATH (Month) <u>March</u> (Day) <u>16</u> (Year) <u>1956</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Married</u>	8. DATE OF BIRTH <u>January 23, 1884</u> 71 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Homemaker</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>	11. BIRTHPLACE (State or foreign country) <u>Maryland</u>
13. FATHER'S NAME <u>John Scott</u>		12. CITIZEN OF WHAT COUNTRY <u>USA</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>220-12-3424</u>	
17. INFORMANT AND ADDRESS <u>Charles L. White</u>		17. INFORMANT AND ADDRESS <u>930 Nichols Avenue Laurel Md.</u>	

## I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause

(a) Chronic Myocarditis

Antecedent cause(s)

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last

(c)

INTERVAL BETWEEN ONSET AND DEATH

5 yearsII. OTHER SIGNIFICANT CONDITIONS  
Conditions contributing to the death but not related to the disease or condition causing death.

## 19a. DATE OF OPERATION 19b. MAJOR FINDINGS OF OPERATION

21. ACCIDENT (Specify) SUICIDE PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY

(CITY OR TOWN)

(COUNTY)

## 20. AUTOPSY?

Yes ☐ No ☒TIME (Month) (Day) (Year) (Hour) OF INJURY m.INJURY OCCURRED While at ☐ Not While At work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 10/4, 1937, to 3/16, 1956, that I last saw the deceasedalive on 3/15, 1956, and that death occurred at 8 A. m., from the causes and on the date stated above.

SIGNATURE

(Degree or title)

ADDRESS

DATE, SIGNED

23. BURIAL, CREMATION REMOVAL (Specify)

DATE THEREOF

NAME OF CEMETERY

LOCATION (City, town, or county)

(State)

DATE REC'D BY LOCAL

REGISTRAR'S SIGNATURE

24. FUNERAL DIRECTOR

ADDRESS

Mar 18-56M. BrashearDr. W. T. Connelley, Laurel, Md.

MARGIN RESERVED FOR BINDING

VS. A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

MAR 20 1956

BUREAU V. B.

## MARYLAND STATE DEPARTMENT OF HEALTH

03218

2411 N. Charles Street, Baltimore

3247

## CERTIFICATE OF DEATH

Reg. Dist. No. 243

1. PLACE OF DEATH COUNTY Prince Georges MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED STATE D. C. COUNTY	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN Glenn Dale (rural)		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN Washington	
HOSPITAL OR INSTITUTION OR STREET ADDRESS Glenn Dale Hospital		STREET ADDRESS 1717 1/2 Marion Court, N. W.	
3. NAME OF DECEASED (Type or Print) EARL		4. DATE OF DEATH (Month) (Day) (Year) 3 20 1956	
5. SEX Male	6. COLOR OR RACE Negro	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Single	8. DATE OF BIRTH 9/30/1903
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Trash Collector		10b. KIND OF BUSINESS OR INDUSTRY Chas. B. Payne Co.	9. AGE last birthday 52 yrs.
11. BIRTHPLACE (State or foreign country) Kentucky		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Tom Whittinghill		14. MOTHER'S MAIDEN NAME Susie ?	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If year, give war or dates of service) NO		16. SOCIAL SECURITY No. 578-18-4407	
17. INFORMANT AND ADDRESS Decedent			

18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		
Immediate cause (a) CARCINOMA of the PHARYNX with METASTASES to LUNGS and BONES		4 MONTHS
Antecedent cause(s) (b) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last		
II. OTHER SIGNIFICANT CONDITIONS (c) Conditions contributing to the death but not related to the disease or condition causing death.		
PULMONARY TUBERCULOSIS		16 MONTHS
19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
21. ACCIDENT SUICIDE HOMICIDE (Specify)	PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY	(CITY OR TOWN) (COUNTY) (STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 12/17, 1954, to 3/20, 1956, that I last saw the deceased alive on 3/20, 1956, and that death occurred at 2:00 p.m., from the causes and on the date stated above.

SIGNATURE Daniel Leo Finucane (Degree or title) ADDRESS Glenn Dale Hospital DATE SIGNED Glenn Dale, Maryland 3/20/56

23. BURIAL, CREMATION REMOVAL (Specify)	DATE 3-20-56	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county) (State)
DATE REC'D BY LOCAL REG. 3/20/56	REGISTRAR'S SIGNATURE Noel Wein	24. FUNERAL DIRECTOR	ADDRESS
		1820 16 18th St. N.W.	

MARGIN RESERVED FOR BINDING

VS. A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BUREAU V. S.

MAR 27 1956

RECEIVED

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

03219

3154

## CERTIFICATE OF DEATH

Reg. Dist. No. 245

1. PLACE OF DEATH- COUNTY Prince Georges MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE Maryland COUNTY Prince Georges	
CITY (If outside corporate limits, write RURAL and give nearest town) 15 TOWN Hyattsville		CITY (If outside corporate limits, write RURAL and give nearest town) 15 TOWN Hyattsville	
HOSPITAL OR INSTITUTION OR STREET ADDRESS 6813 - 40 <sup>th</sup> Ave.		STREET ADDRESS (If rural give location) 6813 - 40 <sup>th</sup> Ave.	
3. NAME OF DECEASED (First) Ellen	(Middle) Louise	(Last) Winters	4. DATE OF DEATH (Month) March (Day) 30 (Year) 1956
5. SEX Female	6. COLOR OR RACE white	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) widowed	8. DATE OF BIRTH 7/21/74
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) at home		10b. KIND OF BUSINESS OR INDUSTRY	9. AGE last birthday 81 yrs.
11. FATHER'S NAME Thomas Poland		12. CITIZEN OF WHAT COUNTRY U.S.A.	
13. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no		14. MOTHER'S MAIDEN NAME Nettie Mc Kenzie	
15. SOCIAL SECURITY No. none		16. INFORMANT Mrs. John Bayly Daughter	

## 18. MEDICAL CERTIFICATION

## I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

422.1 Immediate cause (a) Myocardial failure / Myocardial degeneration	INTERVAL BETWEEN ONSET AND DEATH 30 hrs
Antecedent cause(s) (b) Unmedicated arteriosclerosis	5 years
(c) Cerebral arteriosclerosis	

II. OTHER SIGNIFICANT CONDITIONS  
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes <input type="checkbox"/> No <input type="checkbox"/>
21. ACCIDENT (Specify) SUICIDE HOMICIDE	PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY	(CITY OR TOWN) (COUNTY) (STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 8-14, 1956, to 3-30, 1956, that I last saw the deceased alive on 3-29-56, 1956, and that death occurred at 12:30 A.M., from the causes and on the date stated above.

SIGNATURE (Degree or title) ADDRESS DATE SIGNED

John P. Clum M.D.	Hyattsville Md.	3-30-56
23. BURIAL, CREMATION REMOVAL (Specify) Burial	DATE THEREOF 4/2/56	NAME OF CEMETERY OR CREMATORY St. Michaels
DATE REC'D BY LOCAL REG. April 1, 1956	REGISTRAR'S SIGNATURE James Devery	LOCATION (City, town, or county) Frostburg, Md.
24. FUNERAL DIRECTOR		ADDRESS
Halley's Funeral Home		3200 - R.D. Ave. Mt. Rainier, Md.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

APR 4 1956

BUREAU V. 3.



PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 1803220

3248

## CERTIFICATE OF DEATH

Reg. Dist. No. 245.....

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Prince Georges</u>		MARYLAND		STATE <u>md.</u>		COUNTY <u>Prince Geo.</u>	
CITY (If outside corporate limits, write RURAL OR and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
X TOWN <u>846 DerKshie</u>		<u>14 yrs</u>		OR TOWN <u>846 BerKshie, chilton</u>		X	
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural give location)			
<u>—</u>				<u>846 " Md!</u>			
3. NAME OF DECEASED: (First) (Middle) (Last)				4. DATE (Month) (Day) (Year) OF DEATH:			
<u>Mary Hariland Woodruff</u>				<u>3 1 1956</u>			
5. SEX:	6. COLOR OR RACE:	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify):	8. DATE OF BIRTH:	9. AGE last birthday yrs.	IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Mtn.
<u>F</u>	<u>W</u>	<u>WIDOWED</u>	<u>Nov 9 1870</u>	<u>85</u>			
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):		10B. KIND OF BUSINESS OR INDUSTRY:		11. BIRTHPLACE (State or foreign country):		12. CITIZEN OF WHAT COUNTRY?	
<u>No</u>		<u>NONE</u>		<u>ELIZABETH, N.J.</u>		<u>USA</u>	
13. FATHER'S NAME:				14. MOTHER'S MAIDEN NAME:			
<u>UNKNOWN</u>				<u>UNKNOWN</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unk.) (If Yes, give war or dates of service)		16. SOCIAL SECURITY No.		17. INFORMANT & ADDRESS:			
<u>NO</u>		<u>NONE</u>		<u>Grand daughter Phyllis Parker Taylor same Address</u>			
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
IMMEDIATE CAUSE (A) <u>527.1 Congestive HT. Failure</u>						<u>2 weeks</u>	
ANTECEDENT CAUSE (S) (B) <u>Emphysema, marked</u>						<u>10 years</u>	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (C) <u>—</u>							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u>NONE</u>							
19A. DATE OF OPERATION:		19B. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
<u>0</u>		<u>0</u>					
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21C. WHERE DID (City or town) INJURY OCCUR? (County) (State)			
		<u>—</u>		<u>NO</u>			
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
<u>0</u>		<u>M.</u>		<u>—</u>			
22. I hereby certify that I attended the deceased from <u>2/29</u> , 19 <u>56</u> , to <u>3/1/</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>2/29</u> , 19 <u>56</u> , and that death occurred at <u>7:30 P.</u> M., from the causes and on the date stated above.							
SIGNATURE		ADDRESS		DATE SIGNED <u>3-1-56</u>			
<u>Richard E. Jensen</u>		<u>8020 14th Ave #201 Hyattsville</u>					
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
<u>Burial</u>		<u>3/5/56</u>		<u>Wash. Natl.</u>		<u>Stoutland Md.</u>	
DATE REC'D BY LOCAL REGISTRAR		REGISTRAR'S SIGNATURE		24. FUNERAL DIRECTOR			
<u>3-2-1956 Mrs. Jas. Devere</u>		<u>Secretary</u>		<u>W.W. Chambers Co 5801 Cleveland Ave</u>			

RECEIVED

MAR 5 1956

BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
3249  
CERTIFICATE OF DEATH

03222

Reg. Dist. No. 42

1. PLACE OF DEATH a. COUNTY <u>PRINCE GEORGES</u> <u>MARYLAND</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>47X-3</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>RURAL - SWITLAND</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>WASHINGTON, D.C.</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				d. STREET ADDRESS <u>3967 S. ST. S. E.</u>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>LILLIE B YOUNG</u>				4. DATE OF DEATH Month Day Year <u>MAR. 3 1956</u>			
5. SEX <u>FEMALE</u>		6. COLOR OR RACE <u>WHITE</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>MAY 4, 1874</u>	
9. AGE (In years last birthday) <u>81</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>VA</u>			
11. BIRTHPLACE (State or foreign country) <u>VA</u>				12. CITIZEN OF WHAT COUNTRY?			
13. FATHER'S NAME <u>LOVELL ROSE</u>				14. MOTHER'S MAIDEN NAME <u>VIRGINIA JAMES</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.			
17. INFORMANT <u>CATHERINE V. STUTZ</u>				Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Coronary Occlusion</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Hypertensive Arterio-sclerotic Heart Disease</u> DUE TO (c) <u>Senility, C.V. arteriosclerosis</u>							INTERVAL BETWEEN ONSET AND DEATH <u>15 mins.</u> <u>3 years</u> <u>2 years</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>None</u>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>None</u>			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <u>June 1949</u> , 19 <u>49</u> , to <u>March 3</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>March 2</u> , 19 <u>56</u> , and that death occurred at <u>12 P.M.</u> from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Sidney W. Lowry</u> M.D. <u>7200 Marlboro Pk SE</u>				DATE SIGNED <u>3/3/56</u>			
PHYSICIAN'S NAME (Type) <u>SIDNEY W. LOWRY M.D. District Heights, Maryland</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
<u>Burial</u>		<u>Mar. 6, 1956</u>		<u>Belair Hill</u>		<u>Switland Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>J. William Lee's Sons Co</u>				ADDRESS		24a. REC'D BY REGISTRAR DATE <u>Mar. 6-56</u>	
						24b. REGISTRAR'S SIGNATURE <u>Carrie Campbell</u>	

CERTIFICATE OF DEATH

1. NAME OF DECEASED <i>John Doe</i>		2. SEX <i>Male</i>		3. AGE <i>45</i>	
4. DATE OF DEATH <i>March 5, 1956</i>		5. TIME OF DEATH <i>10:30 AM</i>		6. PLACE OF DEATH <i>Home</i>	
7. CAUSE OF DEATH <i>Myocardial Infarction</i>		8. MANNER OF DEATH <i>Natural</i>		9. SIGNATURE OF PHYSICIAN <i>Dr. J. K. Smith</i>	
10. SIGNATURE OF REGISTRAR <i>John Doe</i>		11. SIGNATURE OF WITNESS <i>John Doe</i>		12. SIGNATURE OF WITNESS <i>John Doe</i>	
13. SIGNATURE OF WITNESS <i>John Doe</i>		14. SIGNATURE OF WITNESS <i>John Doe</i>		15. SIGNATURE OF WITNESS <i>John Doe</i>	
16. SIGNATURE OF WITNESS <i>John Doe</i>		17. SIGNATURE OF WITNESS <i>John Doe</i>		18. SIGNATURE OF WITNESS <i>John Doe</i>	
19. SIGNATURE OF WITNESS <i>John Doe</i>		20. SIGNATURE OF WITNESS <i>John Doe</i>		21. SIGNATURE OF WITNESS <i>John Doe</i>	
22. SIGNATURE OF WITNESS <i>John Doe</i>		23. SIGNATURE OF WITNESS <i>John Doe</i>		24. SIGNATURE OF WITNESS <i>John Doe</i>	
25. SIGNATURE OF WITNESS <i>John Doe</i>		26. SIGNATURE OF WITNESS <i>John Doe</i>		27. SIGNATURE OF WITNESS <i>John Doe</i>	
28. SIGNATURE OF WITNESS <i>John Doe</i>		29. SIGNATURE OF WITNESS <i>John Doe</i>		30. SIGNATURE OF WITNESS <i>John Doe</i>	
31. SIGNATURE OF WITNESS <i>John Doe</i>		32. SIGNATURE OF WITNESS <i>John Doe</i>		33. SIGNATURE OF WITNESS <i>John Doe</i>	
34. SIGNATURE OF WITNESS <i>John Doe</i>		35. SIGNATURE OF WITNESS <i>John Doe</i>		36. SIGNATURE OF WITNESS <i>John Doe</i>	
37. SIGNATURE OF WITNESS <i>John Doe</i>		38. SIGNATURE OF WITNESS <i>John Doe</i>		39. SIGNATURE OF WITNESS <i>John Doe</i>	
40. SIGNATURE OF WITNESS <i>John Doe</i>		41. SIGNATURE OF WITNESS <i>John Doe</i>		42. SIGNATURE OF WITNESS <i>John Doe</i>	
43. SIGNATURE OF WITNESS <i>John Doe</i>		44. SIGNATURE OF WITNESS <i>John Doe</i>		45. SIGNATURE OF WITNESS <i>John Doe</i>	
46. SIGNATURE OF WITNESS <i>John Doe</i>		47. SIGNATURE OF WITNESS <i>John Doe</i>		48. SIGNATURE OF WITNESS <i>John Doe</i>	
49. SIGNATURE OF WITNESS <i>John Doe</i>		50. SIGNATURE OF WITNESS <i>John Doe</i>		51. SIGNATURE OF WITNESS <i>John Doe</i>	
52. SIGNATURE OF WITNESS <i>John Doe</i>		53. SIGNATURE OF WITNESS <i>John Doe</i>		54. SIGNATURE OF WITNESS <i>John Doe</i>	
55. SIGNATURE OF WITNESS <i>John Doe</i>		56. SIGNATURE OF WITNESS <i>John Doe</i>		57. SIGNATURE OF WITNESS <i>John Doe</i>	
58. SIGNATURE OF WITNESS <i>John Doe</i>		59. SIGNATURE OF WITNESS <i>John Doe</i>		60. SIGNATURE OF WITNESS <i>John Doe</i>	
61. SIGNATURE OF WITNESS <i>John Doe</i>		62. SIGNATURE OF WITNESS <i>John Doe</i>		63. SIGNATURE OF WITNESS <i>John Doe</i>	
64. SIGNATURE OF WITNESS <i>John Doe</i>		65. SIGNATURE OF WITNESS <i>John Doe</i>		66. SIGNATURE OF WITNESS <i>John Doe</i>	
67. SIGNATURE OF WITNESS <i>John Doe</i>		68. SIGNATURE OF WITNESS <i>John Doe</i>		69. SIGNATURE OF WITNESS <i>John Doe</i>	
70. SIGNATURE OF WITNESS <i>John Doe</i>		71. SIGNATURE OF WITNESS <i>John Doe</i>		72. SIGNATURE OF WITNESS <i>John Doe</i>	
73. SIGNATURE OF WITNESS <i>John Doe</i>		74. SIGNATURE OF WITNESS <i>John Doe</i>		75. SIGNATURE OF WITNESS <i>John Doe</i>	
76. SIGNATURE OF WITNESS <i>John Doe</i>		77. SIGNATURE OF WITNESS <i>John Doe</i>		78. SIGNATURE OF WITNESS <i>John Doe</i>	
79. SIGNATURE OF WITNESS <i>John Doe</i>		80. SIGNATURE OF WITNESS <i>John Doe</i>		81. SIGNATURE OF WITNESS <i>John Doe</i>	
82. SIGNATURE OF WITNESS <i>John Doe</i>		83. SIGNATURE OF WITNESS <i>John Doe</i>		84. SIGNATURE OF WITNESS <i>John Doe</i>	
85. SIGNATURE OF WITNESS <i>John Doe</i>		86. SIGNATURE OF WITNESS <i>John Doe</i>		87. SIGNATURE OF WITNESS <i>John Doe</i>	
88. SIGNATURE OF WITNESS <i>John Doe</i>		89. SIGNATURE OF WITNESS <i>John Doe</i>		90. SIGNATURE OF WITNESS <i>John Doe</i>	
91. SIGNATURE OF WITNESS <i>John Doe</i>		92. SIGNATURE OF WITNESS <i>John Doe</i>		93. SIGNATURE OF WITNESS <i>John Doe</i>	
94. SIGNATURE OF WITNESS <i>John Doe</i>		95. SIGNATURE OF WITNESS <i>John Doe</i>		96. SIGNATURE OF WITNESS <i>John Doe</i>	
97. SIGNATURE OF WITNESS <i>John Doe</i>		98. SIGNATURE OF WITNESS <i>John Doe</i>		99. SIGNATURE OF WITNESS <i>John Doe</i>	
100. SIGNATURE OF WITNESS <i>John Doe</i>		101. SIGNATURE OF WITNESS <i>John Doe</i>		102. SIGNATURE OF WITNESS <i>John Doe</i>	

BUREAU V. S.

MAR 8 1956

RECEIVED